10-21-13

Stretch Physical Therapy & Total Wellness

Statement of Privacy Notice

Effective June 1, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at **(999) 999-9999**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at **(999) 999-9999**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date

Medical Necessity
All treatments must be justified and medically necessary in order for us to treat and bill you insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measureable and track-able?

Cancel/No-show/Late
Please cancel at least 24 hours prior to treatment. A **$40.00 fee will be charged if you cancel without giving a 24 hour notice.**

Results
The purpose of physical therapy and wellness services is to maximize your body's own healing potential through natural means and promote your own ability to perform daily work, leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes it's more gradual over time.

Minors and Parents
If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all changes and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during or after treatments.

Informed Consent
By accepting these policies, the patient gives the therapist permission to perform the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatments. If you have any questions about your care, be sure to ask the therapist.

It is up to the patient/caretaker to inform the therapist/staff about any health problems or allergies the patient may have. The patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.
Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Insurance Patients
It is your responsibility to know your benefit and insurance coverage for physical therapy services, including maximums and exclusions. You are responsible for all charges in accordance with your insurance policy. As a courtesy we will gladly file your insurance claim for payment to come directly to us. Any balances that exceed 30 days may incur fees and collection costs. If the conditions of your insurance can't be satisfied with a co-pay, you will be required to pay an estimated fee based on your deductible and co-insurance percentage at time of service. The balance will be billed or refunded as appropriate after your claim has been filed.

Non-Insurance or Cash Based Patients
"Cash-based" means that the patient is not using insurance to pay for services. Paying in full at time of service will be required under this option. This option may be advantageous if you have a high deductible that you do not expect to meet.

Billing Policy
Your signature on the registration form that acknowledges you read, understand and accept these policies may be photo-copied and used as authorization for your insurance company to pay us directly. You authorize the release of any medical or other pertinent information to your case to any insurance company, adjuster, or attorney in this case for the purpose of processing claims and securing payment of benefits. You authorize "Stretch Physical Therapy and Total Wellness" to receive payment from your insurance company. . You authorize "Stretch Physical Therapy and Total Wellness" to initiate complaints to the insurance commissioner for any reason on your behalf.

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RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AND PARENTAL CONSENT AGREEMENT

("AGREEMENT")

IN CONSIDERATION of being permitted to participate in the PHYSICAL THERAPY PROGRAM ("Activity") I, for myself for family, friends, representatives, assigns, heirs, and next of kin:

1. ACKNOWLEDGE, agree, and represent that I understand the nature of PHYSICAL THERAPY Activities and that I am qualified, in good health, and in proper physical condition to participate in such Activity. I further agree and warrant that if at any time I believe conditions to be unsafe, I will immediately discontinue further participation in the Activity.
2. FULLY UNDERSTAND THAT: PHYSICAL THERAPY ACTIVITIES INVOLVE RISKS AND DANGERS OF SERIOUS BODILY INJURY, INCLUDING PERMANENT DISABILITY, PARALYSIS, AND DEATH ("RISKS"); (b) these Risks and dangers may be caused by my own actions or inaction's, the actions or inaction's of others participating in the Activity, the condition in which the Activity takes place, or THE NEGLIGENCE OF THE "RELEASEES" NAMED BELOW; (c) there may be OTHER RISK AND SOCIAL AND ECONOMIC LOSSES either not known to me or not readily foreseeable at this time; and I FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, AND DAMAGES I incur as a result of my participation or that of the minor in the Activity.
3. HEREBY RELEASE, DISCHARGE, AND COVENANT NOT TO SUE INDEFREE PHYSICAL THERAPY OR INDEFREE ASSOCIATION OR their respective administrators, directors, agents, officers, members, volunteers, and employees, other participants, any sponsors, advertisers, and, if applicable, owner and lessors of premises on which the Activity takes place, (each considered one of the "RELEASEES" herein) FROM ALL LIABILITY, CLAIMS, DEMANDS, LOSSES, OR DAMAGES ON MY ACCOUNT CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OF THE "RELEASEES" OR OTHERWISE, INCLUDING NEGLIGENT RESCUE OPERATIONS AND I FURTHER AGREE that if, despite this RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AGREEMENT I, or anyone on my behalf, makes a claim against any of the Releasees, I WILL INDEMNIFY, SAVE, AND HOLD HARMLESS EACH OF THE RELEASEES from any litigation expenses, attorney fees, loss, liability, damage, or cost which may incur as the result of such claim.

I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

Printed Name of PATIENT/PARTICIPANT: _____

Address: _____(Street) (City) (State)(Zip)

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