NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PERFORMANCE PHYSICAL THERAPY
12525 EAST MISSION #104
SPOKANE, WA 99216

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I give authorization to Performance Physical Therapy to discuss my medical condition, statement of account, and appointment scheduling issues with:
AUTHORIZED PERSON'S NAME _____
RELATIONSHIP TO PATIENT _____

PATIENT NAME _____

SIGNATURE OF PATIENT (or legal guardian) _____
RELATIONSHIP TO PATIENT _____
DATE _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:
Initials:
Reason:

NOTICE OF PRIVACY PRACTICES

PERFORMANCE PHYSICAL THERAPY
12525 EAST MISSION #104
SPOKANE, WA 99216

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

Your personal healthcare information is used for **treatment** purposes which include discussing your care with your physicians or discussing treatment options with other therapists in this office. In order to receive **payment** from your insurance company, it may be necessary that we disclose your personal healthcare information to such insurance company for medical necessity reviews and appeals. We also may use your personal healthcare information for our internal **healthcare operations** such as chart audits and peer-review audits. If we receive a request for your information that does not fall into the categories as listed above, a written authorization with your signature will be required before such disclosure takes place. Once we have disclosed your records, we are not responsible for any re-disclosure of your information that may take place by the recipient of this information. We require a signed authorization from you as well to designate another person (spouse, family representative,caregiver,etc.) to have access to your medical condition information, information regarding payment issues and account status, or information regarding any appointments you may have scheduled with us. You may revoke this authorization at any time.

Due to the nature of physical therapy services, we use an open gym for exercise purposes. There is a chance you may be seen by other patients while you are using our exercise equipment or coming and going for your appointment. Reasonable efforts will be made with oral communication (lowered voices) to minimize disclosure of your information. To protect your privacy, our sign-in sheets have been designed so that you sign in by first name and last initial only. To alert you to come back for your treatment, you will be called by your first name only. We may also need to leave a message for you on your answering machine from time to time. You will also be receiving statements of your account in the mail from our office.

We are committed to protecting the security and integrity of your personal healthcare information through procedures and technology designed for this purpose. We maintain policies and procedures covering the proper physical security of workplaces and records. We require independent contractors and outside companies (brace representatives, etc.) who work with us to adhere to our strict privacy standards.

PATIENT RIGHTS

- You have the right to copy and inspect your records.
- You have the right to request an amendment of information in your records.
- You have the right to file a complaint.
- You have the right to request restrictions on the use and disclosure of your records.
- You have the right to request a history of account of the use and disclosure of your records.

Please notify our privacy contact personnel, Katie Walsh at this office at 928-1500 if you have any questions or concerns regarding this notice. We assure you that complaints will not be met with retaliation of any kind, and your complaint will be investigated with report back to you with the outcome of such investigation.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice from this office.

PATIENT INFORMATION
PLEASE PRINT…THANK YOU

Patient Name: _____ Birthdate:_____Age_____ Male___Female___

Street Address: _____City_____ State_____ Zip _____

Mailing Address: _____City_____ State_____ Zip _____

Home Phone#:_____ Cell Phone# _____SS#_____ Marital Status: ____

Employer: _____May we call you at work?_____Work phone#_____

Employment status: (please circle) full time, part time, retired, unemployed or disabled.

Name of person to contact in emergency: _____Phone#:_____

GUARANTOR: **(If patient is a minor, this is the parent/guardian who is seeking care from our office.)**
Name: _____ Birthdate:_____SS#_____

Place of Employment:_____ Work phone#:_____ May we call work?_____

INSURANCE INFORMATION
Primary Insurance: _____Secondary Insurance_____

ID/Claim#:_____ ID/Claim#:_____

Group#:_____Group#:_____

Subscriber's Name:_____ Subscriber's Name:_____

If auto insurance, do you have personal injury protection (PIP) to pay your medical bills?:_____

Adjuster: _____ Adjuster's phone#:_____

Have you retained an attorney?_____If yes, who?_____Phone#_____

ACCIDENT/ILLNESS INFORMATION
What are we seeing you for?_____Injury date_____Surgery date_____

How did it occur?_____ At work?_____Auto injury?_____

If on the job injury, who were you employed by at the time?_____

PHYSICIAN INFORMATION
Referring physician_____Family physician_____
Do you have any other medical problems?_____If yes, please describe_____

_____

Have you ever had physical therapy before?_____If yes, when?_____

How did you hear about our office?_____

_____

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize treatment by PERFORMANCE PHYSICAL THERAPY for the above-named patient. Authorization is also granted for my insurance company to pay directly to Performance Physical Therapy. I acknowledge that my insurance carrier may limit my physical therapy benefits. I acknowledge that I am financially responsible for all charges not covered by this assignment. I hereby authorize the release of any medical information necessary to process this claim.

FOR MEDICARE PATIENTS: (In lieu of HCFA 1500)-I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to PERFORMANCE PHYSICAL THERAPY. I authorize any holder of medical information about me to release to the HEALTHCARE FIN. ADM. and its agents any information needed to determine these benefits or the benefits payable for related services.

NOTICE OF INFORMATION PRACTICES: We keep a record of the health care services we provide you. You may ask us to see and copy that record (copying fees may be charged). You may also ask us to amend that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it here at our office

_____ _____
SIGNATURE **DATE**

_____
PRINT NAME