

NOTICE OF INFORMATION AND PRIVACY PRACTICES

The privacy of your health information is an important issue. Please read the following regarding your rights as they relate to your Protected Health Information (PHI).

It is our policy to fax a copy of your initial evaluation to your referring doctor as well as your primary care doctor.

Patients may request additional restrictions on access to their PHI:

1. Individuals have the right to agree or object to disclosure practices at this office. The Notice of Information Practices will inform individual of this right. When a patient requires specific restrictions on disclosure of their health information, this information will be documented in the patient's record. The specific restrictions will be indicated and highlighted on the flow sheet with the actual restriction being placed behind the sign-in sheet in the medical record so the restriction will not be inadvertently violated.
2. Prior to disclosure of any PHI, every chart will be checked to ascertain whether or not the patient has requested additional restrictions on access to their PHI.
3. When a requested restriction pertains to uses and disclosures related to treatment, payment, and health care operations and it is determined that Physical Therapy at Dawn cannot comply with the request, the patient will be informed in writing. This information will be documented in the patient's record and maintained for six years.

Patients have the right to inspect and to receive copies of their health information (except psychotherapy notes and information in a criminal, civil, or administrative action):

1. Individuals may request access in writing. Physical Therapy at Dawn will have 30 days from receipt of the request to:
 - (a) make the information available;
 - (b) provide a written response to the individual indicating that the information is unavailable or has been destroyed; or,
 - (c) provide a written notice to the individual indicating that access is denied.
2. When access is denied the notice will inform the patient of his or her right to appeal the decision through the Privacy Officer and/or by contacting the Secretary of HHS.
3. Provider must then promptly designate and refer the matter to a licensed health care professional who is not directly involved in the denial of review to review the decision to deny access. The reviewing official must determine, within a reasonable time, whether or not to deny access based on regulatory standards. The CE must promptly provide written notice to the individual of the determination and his or her appeal rights through the Secretary of HHS.
4. Any directive received from the Secretary of HHS regarding access to the record will be complied with.
5. All activities related to access will be documented and maintained in the patient record for six years.

Patients have the right to amend their health information:

1. Individuals may request the amendment in writing. Physical Therapy at Dawn will have 30 days from receipt of the request to:
 - (a) accept the amendment,
 - (b) provide a written response to the individual indicating that the information is unavailable and has been destroyed; or,
 - (c) provide a written notice to the individual indicating that the request is denied and informing the patient of his or her right to appeal this decision by contacting the Secretary of HHS.
2. In any event, the patient may add his or her note to the record.
3. The provider will obtain the individual's identification of person's and entities to whom the amendment will be relevant, and authorization to inform these entities of the amendment or addition.
4. Provider will inform the relevant parties after receiving authorization.
5. Any directive received from the Secretary of HHS regarding access to the record will be complied with.
6. All activities related to access will be documented and maintained in the patient record for six years.

PHYSICAL THERAPY AT DAWN
FINANCIAL POLICY

Physical Therapy at Dawn is committed to providing you with the best possible care. In an effort to minimize confusion, we would like to take this opportunity to review our financial policies with you.

Cash Policy: If you do not have insurance coverage and will be paying on a cash basis, payment for your treatment will be due in full at each treatment session. We offer a discount off our regular fee schedule.

Contracted Insurance Policy:

1. Payment is due at the time of service for all co-pays, coinsurance, deductibles and non-covered services. We accept cash, check, or credit card.

2. If you have medical insurance, we are eager to help you receive your maximum allowable benefits.

a. Please provide us with complete information for all primary and secondary insurance carriers at your initial appointment. If you have both primary and secondary insurance, you will be responsible for notifying us which is primary and which is secondary. If your insurance information changes during the course of treatment, please notify us immediately or you will be responsible for the balance of the bill if it is unpaid. b. As a courtesy, we will verify coverage and benefit eligibility. We would advise you to also check your benefits. Unfortunately, there are no guarantees of benefit reimbursement until claims are received and processed by your insurance company.

c. We will require you to assign all insurance company payments directly to our office to avoid any misunderstandings regarding payment for professional services.

d. If any portion of your co-pay, coinsurance and/or deductible is unmet at the time the claim is paid by your insurance carrier, you will be billed for the outstanding amount. If you have an overpayment on your account after it has been paid in full, we will be happy to refund the overpaid amount to the appropriate payer within thirty days of receipt of the last payment.

Non-Contracted Insurance Policy: Physical Therapy at Dawn is not a party to this contract. As a courtesy we will verify eligibility and benefits as well as bill your insurance company. You will be responsible for all monies due at time of service.

Litigated Claims, Third Party Claims or Letters of Protection: We do not accept litigated claims, third party claims or letters of protection. However, if at any time during your treatment your claim becomes a third party liability, you will be required to pay for your services in full at each visit.

Workers' Compensation: We require approval/authorization by your workers' compensation carrier prior to your initial visit. If the claim is denied, you will be responsible for payment in full.

Medicare: By law we are required to file your claim to Medicare. As a courtesy, we track or file your secondary insurance. If you do not have a secondary insurance to Medicare, you will be required to pay your 20% responsibility, including any unmet deductible, at time of service.

Divorce: In cases of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer the account for collections, you agree to pay all the collection costs incurred, including attorney, and/or court costs. In case of suit, you agree the venue shall be Albuquerque, New Mexico.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to go court, or if your past due status is reported to a credit reporting agency, the fact you received treatment in our office may become a matter of public record.

Returned Checks: There is a fee (currently \$35) for any checks returned by the bank.

Effective Date: Once you have signed this agreement, you understand and agree to all the terms and conditions contained herein, and the agreement will be in full force and effect.

CONSENT FOR MEDICAL TREATMENT

In the interest of providing you, our patient, with the information required to make informed decisions regarding your care and your right to refuse care, we ask you read the following:

Physical therapy includes all procedures, techniques, and services provided by licensed physical therapists. Therapy includes joint responsibility for the improvement of health between the treating therapist and the patient. Therapy may include exercise specific to the condition which caused you to seek treatment, modalities for therapeutic effect, education regarding condition, and/or manual therapy. Specific interventions will be suggested by your treating therapist. You are encouraged to ask questions to further your understanding of your therapy and are reminded that at anytime you may refuse treatment. Refusal of treatment may result in termination of therapy if the treating therapist determines that the refused intervention is essential to your success as a patient.

Your signature below indicates your **CONSENT TO BE TREATED** at Physical Therapy at Dawn, your acknowledged receipt of the **NOTICE OF INFORMATION AND PRIVACY PRACTICES** as well as your acknowledgement of our **FINANCIAL POLICY**.

Patient Signature

Date

MEDICAL RECORDS RELEASE

The undersigned authorizes payment directly to Physical Therapy at Dawn for treatment and healthcare operations. It is understood that by signing below, I am responsible for any or all charges not covered by my insurance company and any charges not paid may be placed with an attorney for collection. I have read and understand all foregoing statements and contents.

Printed Name of Patient _____

Signature of Patient or Legally Authorized Representative

Date

CONSENT TO TREAT MINOR

Physical Therapy at Dawn requires authorization to treat minor children in the absence of the parent or legal guardian.

Name of Minor

Date of Birth

Parent(s)/Legal Guardian(s) Signature

Date