Art of Health Physical Therapy, P.C.

AUTHROZATION FOR TREATMENT

I do hereby agree and give my consent for *Art of Health Physical Therapy, PC* to perform a physical therapy evaluation and/or rehabilitative treatment. Treatment and care may include but not limited to manual therapy (i.e. myofascial release, soft tissue mobilization, connective tissue mobilization, trigger point release, visceral mobilization, cranio-sacral therapy), therapeutic exercises, balance training, neuro-muscular-re-education and/or client education of posture and body mechanics.
I hereby give authorization for the performance of such rehabilitation procedures as permitted by the New York Statutes under the appropriate scope of practice act, in the judgement of my physical therapist, deemed necessary.

I understand that, as in the practice of medicine, physical therapy treatment may have some risks. I understand that I have the right to ask about these risks and have any of my questions answered prior to treatment.

Patient/Parent/Guardian Signature _____ Date _____

CANCELLATION/NO SHOW/LATE POLICY

Art of Health Physical Therapy, PC has a 24-hour cancellation policy.
I will provide Art of Health Physical Therapy. PC with a written or verbal cancellation no later than 24 hours prior to my scheduled appointment time. *If I failed to do so, I will incur a fee of $95*. The fee will be waived if the cancellation or no show is the result of an emergency.
If I am late to an appointment or must leave early, I understand that I will be treated only for the remaining time and will be responsible to pay for the whole session.

I have read the above policy and by signing this form, I agree to the cancellation/no show policy of Art of Health Physical Therapy, PC.

Patient/Parent/Guardian Signature _____ Date _____

Tel # (917) 620-7672
Fax# (516) 740-3879
Email: info@artofhealthpt.com
www.artofhealthpt.com

Art of Health Physical Therapy, P.C.

PAYMENT POLICY/PATIENT AGREEMENT

Art of Health Physical Therapy, PC is NOT a contracted health care provider with any insurance companies.

I understand that there may be a possibility that my treatments at Art of Health Physical Therapy, PC may not be reimbursed back to me by my insurance company and that reimbursement is highly dependent on my "out of network" benefits. I acknowledge that it is my responsibility to be informed about the details of my particular insurance plan and that I will pay for the treatment at the time the service is rendered, then submit the bill for reimbursement if I choose to do so.

I agree to pay Art of Health Physical Therapy, PC for the services rendered to me at the course of my treatment. I shall be personally responsible for any unpaid balance to this office. If I do not pay for the charges that are my responsibility, I agree to pay Art of Health Physical Therapy, PC collections costs including attorney and court fees.

Patient/Parent/Guardian Signature _____ Date _____

PRIVACY NOTICE/AUTHORZATION FOR RELEASE OF INFORMATION

I understand that Art of Health Physical Therapy, PC will maintain my privacy to the highest standards.

Photographs taken during the initial evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below, I consent to the use of these photographs in a professional manner.

I agree that Art of Health Physical Therapy. PC may provide information from my medical record to persons involved in my medical care.

I agree that Art of Health Physical Therapy. PC may use or disclose my personal health information for the purposes of carrying out a treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I agree that Art of Health Physical Therapy. PC may obtain information from others who have provided medical care to me and/or responsible for the payment of all or part of my bills when this information is needed in order to treat, bill and/or receive payment.

I have read the "Notice of Privacy Practices" mandated by HIPAA.

Patient/Parent/Guardian Signature _____ Date _____

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"Notice of Privacy Practices' s mandated by HIPAA

This notice describes how medical information about you may be used or disclosed and how you can get access to this information. Please review this document carefully.

If you have any questions about this notice or if you need more information, please contact our
Privacy Officer: Charmaine Quijano, PT, DPT
Mailing address: 2900 Hempstead Turnpike, Suite 217 Levittown, NY 11756
Telephone #: (917) 620-7672 Fax #: (516) 740-3879

About This Notice: We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights- and we have certain legal obligations- regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health r conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information.

We may use and disclose your Protected Health Information in the following circumstances:

- For treatment (provide, manage and coordinate your medical care). For example, your Protected health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- For payment for the services that we provided to you. This use and disclose may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to reimburse you for the treatment we provided.

- For appointment Reminders/Treatment Alternatives/ Health-Related Benefits and Services. We may contact you to remind you that you have an appointment for medial care, or contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- For our clients who are minors, disclosure of their Protected Health Information to their parents or guardians unless such disclosure is otherwise prohibited by law. (Optional, only included if applicable.)

- For research purposes only if the research has been specifically approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and protocols have been set up to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow

them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of any, Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose a limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality ad security of the data, and (3) not identify the information or use it to contact any individual.

- When required to do so by international, federal, state or local law.
- For prevention of a serious threat to your health/safety or to a health/safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- To our business associates who perform functions on our behalf or provide us with services. For example, we may use another company to do our billing or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us to protect he privacy and ensure the security of your Protected Health Information.
- To worker's compensation or similar programs that provide benefits for work-related injuries or illness.
- If it involves public health risks which may include: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury, or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To the appropriate government authority if we believe that a patient has been a victim of abuse, neglect or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- To a health oversight agency for activities authorized by law which may include audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil right laws.
- To provide legally required notices of unauthorized access to or disclosure of your health information.
- In response to a court or administrative order such as subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.
- Individuals involved in your care or payment for your care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to

such disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Your Rights Regarding Your Protected Health Information

- Right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request in certain limited circumstances but this denial can be reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- Right to be provided with a summary of your Protected health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay for the associated fees.

- If your Health Protected Information is maintained in an electronic format, you have the right to request that electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form you request, if it is readily reproducible in such form or format.

- You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- You have the right to request amendments if you feel that the Protected Health Information we have is incorrect or incomplete for as long as the information is kept by or for us. This request must be made in writing to the Privacy Officer at the address provided at the beginning of this notice. In certain cases, we may deny your request for an amendment and you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- You have the right to request a restriction or limitation on the Protected health Information we use or disclose for treatment, payment, or health care operations. To do this, you must submit a written request to the Privacy Officer that states specific restriction and to whom you want this restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full.

- If you paid “out-of-pocket” in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we may contact you by mail at a specific address or call you only at your work number. We will try to accommodate all reasonable requests.

- You have the right to obtain a paper copy of this Notice even if you agreed to receive it electronically at any time.

Changes To This Notice

- We reserved the right to change this Notice. We reserve the right to make the changed Notice effective for Protective Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice will be posted on our website.

Complaints

- You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your rights have been violated.
  - To file a complaint with us, contact our Privacy Officer at the address listed in the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.
  - To file a complaint with the Secretary, mail your letter to:

Secretary of the US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington DC 20201
Or call toll free at (877) 696-6775
There will be no retaliation against you for filing a complaint.