PHYSICAL THERAPY OF SARASOTA

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NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who might be consulted by staff members.

Payment Your health information may be used to seek payment from you health plan, from other sources of coverage such as automobile insurer, or from other companies that you may use to pay for services.

Health care operations. Your health information may be used as necessary to support the day to day activities and management of Physical Therapy of Sarasota.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without you permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of you information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information may be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- ☐ The right to request restrictions on the use and disclosure of your protected health information
- ☐ The right to receive confidential communications concerning your medical condition and treatment
- ☐ The right to inspect and copy your protected health information
- ☐ The right to amend or submit corrections you your protected health information
- ☐ The right to receive an accounting of how and to whom your protected health information has been disclosed.
- ☐ The right to receive a printed copy of this notice

Physical Therapy of Sarasota Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice and will notify you if we cannot agree to a requested restriction.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the front office staff or Privacy Official/Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny it.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Physical Therapy of Sarasota, 2650 Bahia Vista Street Suite 101, Sarasota, FL 34239

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or other wise retaliated against for filing a complaint.

Effective Date: April 14, 2003

Signature

I have read and understand this notice of privacy practices.

Patient's Name (Print or Type) Signature of Patient Date

Signature of Patient Representative (if patient is unable to sign or is a minor) Relationship

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PATIENT CONSENT FORM

By signing this form, you are granting consent to Physical Therapy of Sarasota to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at (941) 365-2830 or by accessing our website at www.physicaltherapyofsarasota.com.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____ _____

Signature of Patient or Legal Representative Date

OPTIONAL

☐ I request the following restrictions to the use of disclosure of my health information:

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Signature of Patient or Legal Representative Witness Date

☐ Accepted ☐ Denied

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Signature Title Date

02/06

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MEDICAL HISTORY

Patient Name: **Age:** **Date:**

Occupation_____ Who referred you to us?_____
Date last seen by doctor_____ Next doctor appointment _____
Hobbies/sporting activities you do frequently: golf, tennis, swimming, other _____
Marital Status: S / M / D / W / O Are you or could you be pregnant? _____
Your diagnosis as told to you by your doctor: _____
Prior to seeing us today, how have you been treated for your diagnosis? _____
_____
Medication (list for complaint that brings you to see us) _____
_____
Injections (list) _____
_____ Surgeries (type & date) _____
_____ Therapy (list what and for how long) _____
_____ Other _____

Have you recently had any of the following test for your current diagnosis? (check all that apply)
☐ EMG ☐ CAT SCAN ☐ MYELOGRAM ☐ X-RAY ☐ MRI
Have you had someone come to your home to provide care/assistance? ☐ No ☐ Yes If yes, what agency provided your care?_____ Are you still under their care? _____

Past Medical History

Have you ever been diagnosed with any of the following problems?
Please check all that apply and describe in the space provided.

**Describe in space provided*

☐ Cardiac Problems
☐ High Blood Pressure
☐ Diabetes
☐ Headaches
☐ Dizzy Spells
☐ Fainting Spells
☐ Epilepsy
☐ Stroke
☐ Seizures
☐ Back Injury
☐ Bleeding disorder
☐ Pacemaker
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Osteoporosis/Osteopenia
☐ *Respiratory Problems _____
☐ *Allergies _____
☐ *Fracture _____
☐ *Cancer _____
☐ *Metal Implants _____

Medication (s) (Other than listed above) : _____
_____

Your complaint is: _____
Is this due to an accident? ☐ Yes ☐ No Date of Accident & where it happened: _____
Date your complaint started: _____ How did it occur? _____
Since it started are you getting ☐ Worse ☐ Better ☐ No Different

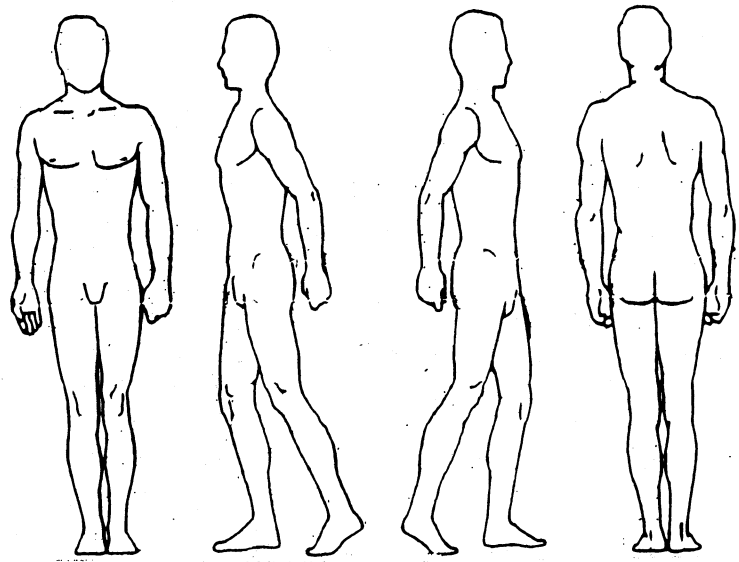
Review physical activities listed below and check the appropriate answer in how it affects your complaint:

Standing still	☐Worse	☐Better	☐No effect
Walking	☐Worse	☐Better	☐No effect
Bending forward	☐Worse	☐Better	☐No effect
Bending backward	☐Worse	☐Better	☐No effect
Sitting in a hard chair	☐Worse	☐Better	☐No effect
Sitting in a soft chair	☐Worse	☐Better	☐No effect
Lying on stomach	☐Worse	☐Better	☐No effect
Lying on side	☐Worse	☐Better	☐No effect
Rising from a chair	☐Worse	☐Better	☐No effect
Squatting down	☐Worse	☐Better	☐No Effect
Stepping up stairs	☐Worse	☐Better	☐No effect
Stepping down stairs	☐Worse	☐Better	☐No effect
Reaching overhead with arm	☐Worse	☐Better	☐No effect
Turning neck	☐Worse	☐Better	☐No effect
Turning body	☐Worse	☐Better	☐No effect
Reaching behind back	☐Worse	☐Better	☐No effect
In the morning	☐Worse	☐Better	☐No effect
In the afternoon	☐Worse	☐Better	☐No effect
In the evening	☐Worse	☐Better	☐No effect

- If I had to name one activity that really increases my symptoms, it would be _____
- My **personal goal/objective** for therapy is _____
- Place a mark on the scale where your pain falls |_____|

Pain free **Severe**

Use an X to indicate where Your complaint is located



Front **Left Side** **Right Side** **Back**

I give my permission to be treated at Physical Therapy of Sarasota. I authorize the provider to release any information in connection with my treatment to physicians, insurance companies and employers (for Worker's Compensation cases) requesting such information. I also assign any insurance benefits payable to Physical Therapy of Sarasota.

Patient's Signature _____ Date _____

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PHYSICAL THERAPY OF SARASOTA – FINANCIAL POLICY

Thank you for choosing us to be your therapy provider. It is important for you to understand our financial policy before beginning treatment. Please read and sign the following form and do not hesitate to ask us any questions regarding our financial policy.

Medicare: As a participating provider, we will file your claims. Medicare has a yearly medical deductible of $124.00. There is a cap for the year of 2006 which is $1740.00. You are responsible for: (1) Any supplies purchased. (2) If your secondary insurance is not a Medigap or automatic crossover, you will be responsible for the 20% not covered by Medicare. (3) Any of your yearly deductible met at our office.

Private Policies: As a courtesy to you. We will file to your primary insurance company. You will be responsible at the time of service for any portion not covered. If your insurance company has not paid your account in full within 45 days from the time of treatment, the balance will be billed to you.

HMO/PPO: We are participating providers in many networks. It is **your responsibility** to verify with your insurance plan that we are a provider with them and to know their limitations. We have accepted your insurance company's fee schedule. **Co-pays are due before each office visit.** Some insurances charge the patient a cost share amount. We will notify you of your portion with a monthly statement. Some **HMO** insurance policies require a referral form from the primary physician. **Patients must bring this form, or have it faxed to us, before their first visit.**

Liability/Auto: You are responsible for 10% of your visit charge and any portion your insurance company does not cover, regardless of their determination or usual and customary rates (Beech Street plans are excluded).

Patients that are not covered in any of the above groups must pay for services at the time they are performed.

We will be glad to discuss payment schedules if arrangements are made in advance. Overdue accounts will be submitted to our collection agency and you will be responsible for all costs incurred if collection proceedings are used.

It is the patient's responsibility to check on the limits and exclusions of their insurance policy. Your insurance policy is a contract between you and your insurance company and you are ultimately responsible for any charge incurred for your medical care.

I have read and understand the above Financial Policy and agree to abide by it.

_____ _____

Patient or Responsible Party Signature Date

02/06