AFFILIATED PHYSICAL THERAPY, LLC

NOTICE OF PATIENT INFORMATION PRACTICES

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

AFFILIATED PHYSICAL THERAPY'S LEGAL DUTY

Affiliated Physical Therapy, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Affiliated Physical Therapy uses your personal health information primarily for treatment (sending medical information to your physician), obtaining payment for treatment (sending chart notes to the insurance company); conducting internal administrative activities and evaluating the quality of care that we provide (having charts audited for quality assurance review). For example, Affiliated Physical Therapy may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives or other health related benefits that could be of interest to you. Affiliated Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, Affiliated Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. Affiliated Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Affiliated Physical Therapy will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Affiliated Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Affiliated Physical Therapy's health information practices or if you have a complaint, please contact the following person:

AFFILIATED PHYSICAL THERAPY, LLC
Office Manager

2A Cherry Tree Drive, Nutter Fort, WV 26301-4475
Telephone: (304) 622-5822 Fax: (304) 622-9707

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Affiliated Physical Therapy's Notice of Information Practices. I understand that Affiliated Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Affiliated Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Affiliated Physical Therapy's Provider's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

CONSENT FOR TREATMENT

Thank you for choosing Affiliated Physical Therapy, LLC, you will be seen by one of our following physical therapists: Andrew Spatafore, MSPT or Matthew Madrid, MSPT and/or our current licensed physical therapy assistants. From time to time, we may have physical therapy and/or physical therapy assistant student interns who may provide evaluation and/or treatment under the direct supervision of a Physical Therapist. You have the right to refuse treatment by an intern by advising the staff of your decision. The information listed below is required to assure prompt and quality care. Please read this consent for treatment and sign the registration form (#116), indicating you have done so.

To insure prompt, quality care, it is your responsibility to:

1. Supply us with a physician referral, insurance claim information, release forms, etc., to ensure proper billing
2. Make sure we have updated physician referrals/signed plans of care, insurance/worker's compensation approval, ect. as needed
3. Give us correct information regarding your problems so that we may properly assess you and develop a plan for treatment, as well as providing us with ongoing information regarding your status
4. Feel free to ask any questions you may have regarding your treatment
5. Stop at the appointment desk located at the entrance to the gym area to schedule upcoming appointments
6. Inform us as soon as possible if you need to cancel an appointment or change a scheduled time
7. Follow home programs as prescribed within tolerance levels, or inform us if you do not and reason why, especially if due to increased symptoms, noncompliance may slow/hinder your progress
8. Inform us of upcoming physician appointments so we may have a chance to prepare a progress evaluation for your physician
9. Inform us of any medical conditions that may affect treatment rendered, such as pregnancy, diabetes, pacemakers/defibrillators, high blood pressure, cancer and/or any infectious disease so that appropriate precautionary measures may be taken
10. Inform us if you wish to discontinue treatment at any time and reason(s) for doing so

It is our responsibility to:

1. Collect information for billing and assessment purposes
2. Provide treatment as promptly as possible
3. Answer any questions you have regarding your treatment
4. Submit progress reports to your physician, worker's compensation, insurance companies, attorney, ect. as needed
5. To discontinue treatments if progress is no longer being made or of you have reached maximum benefit

You will receive treatment based on an evaluation/assessment of your problem. Treatments may include, but are not limited to, evaluation, moist heat, ice, therapeutic exercises, development of home programs, myofascial release, stretching, traction, ultrasound, electrical stimulation, and iontophoresis. Not all treatment options are covered by all payers. You may be given the option of paying out of pocket for items such as tape or braces, if you insurance carrier deems these are not a covered benefit. Your treatment will be designed to achieve maximum benefit and may be changed/modified as indicated. In general, physical therapy interventions are very safe and there is very little chance of injury. The most common complaints are of muscle soreness after exercises. It is **VERY IMPORTANT** for you to let us know of any discomfort during treatment, so that we may discontinue, change or modify your treatment as necessary. Please feel free to ask any questions you may have regarding your treatment. You have the right to be involved in your care and may choose not to receive a specific treatment or to defer any treatment at any time by informing us of your preferences.

If I am injured or harmed in any way during the course of my treatment at Affiliated Physical Therapy in the gym or pool area while receiving assistance from my caregiver, I will not hold Affiliated Physical Therapy responsible or liable if this occurs during, but not limited to, dressing, undressing, toileting or showering.

I have read and understand the above statements. I understand that I have a right to know the nature of proposed treatment, the benefits of the proposed treatment, the most common risks associated with proposed treatment and reasonable alternatives to such proposed treatment. I understand that I have a right to choose where I want to receive treatment.

LETTER TO PATIENT EXPLAINING NOTICE OF INFORMATION PRACTICES

Dear Patient,

Affiliated Physical Therapy protects the confidentiality of your protected health information in accordance with state and federal laws with regards to files stored in our facility and through employing computer security measures. We also take precautions in our office to safeguard your health information by undergoing HIPPA (Health Insurance Portability and Accountability Act) training with the passing of a written exam required.

The federal government has published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health care insurance plans. These regulations protect virtually all patients regardless of where they live or where they receive their health care. Every time you see a medical provider, are admitted to the hospital, fill a prescription or send an insurance form to a health plan, the hospital or other health care provider will need to consider such rules. All health information including paper records, oral communication and electronic formats (such as email) are protected by the privacy rules.

The Notice of Patient Information Practices which you were provided and read, contains important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information. Please feel free to ask any questions you may have regarding this notice.

Thank you,

Affiliated Physical Therapy, LLC

AFFILIATED PHYSICAL THERAPY

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information

Authorized Individuals:

Name: ______________________________ Relationship: ________________________

Name: ______________________________ Relationship: ________________________

Name: ______________________________ Relationship: ________________________

Name: ______________________________ Relationship: ________________________

Password provided to authorized individuals for phone communication: ___________________

____
Patient Name

____
Patient Signature

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Date

A valid picture ID of authorized individual must be presented in order to verify individual's identity, before any information is released

In the case of decedents, the individual must present a copy of the death certificate along with a valid picture ID

If the individual would like to allow information to be provided over the phone, they may provide the individuals with a password to be verified from information above, prior to release of any information to the individual