restorations physical therapy

Notice of Privacy Practices & HIPAA Compliance

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.

1) Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities. You may opt out of any of these Special Uses at any time by informing a staff member or marking it on your Patient Registration form.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Patient Bill of Rights

Every patient is entitled to be served by staff that is willing and eager to assist them.

Every patient is entitled to the experience and knowledge that our staff has to offer.

Every patient is entitled to having all information regarding fees and payment plans regardless of their financial status.

Every patient is entitled to report all positive or negative feedback. Please report all feedback to the Office Manager (becky@restorationspt.com) or Owner (annie@restorationspt.com) either by email or phone (412-206-9202). Any written negative feedback will be responded to within 5 business days (if Medicare, within 14 days).

Hours of Operation

Monday through Thursday: 8:00 am – 8:00 pm
Friday: 8:00 am – 4:30 pm
Saturday & Sunday: Closed

Voicemails are forwarded to staff 24-hours. If you have a question or need to change or make an appointment, and it is before or after business hours, please leave a voicemail.

restorations physical therapy **Consent for Treatment/Financial Agreement/HIPAA & Acknowledgement**

CONSENT: You understand that physical therapy involves the use of many different types of physical evaluation and treatment. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. Restorations Physical Therapy is not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. You understand there is also a risk that treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is administering based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

RELEASE OF INFORMATION: You agree that the Facility may disclose your "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including , but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers. This includes appropriate release and disclosure of your medical records in compliance with Privacy Provisions to your physicians and other health care providers when necessary for your treatment and general health. While you are in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

FINANCIAL POLICY STATEMENT: As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill. You are responsible for payment of any co-payments at the time of service. If your insurance carrier does not remit payment once billed, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to Restorations Physical Therapy.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

I, the undersigned, do hereby agree and give my consent for Restorations Physical Therapy to furnish Therapy Treatment. I understand my responsibility for payment of my account. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Print Name:_____

Signed:_____ **Date:**_____

Patient/Guardian/Responsible Party

Please read & initial as appropriate:

_____ **I acknowledge that I have reviewed Restorations PT's privacy policy & have been offered a copy for my records.**

_____ **I acknowledge that I have reviewed Restorations PT's Patient Bill of Rights & Hours & have been offered a copy for my records.**

_____ **I would like to opt out of emails regarding Restorations PT's fundraising efforts.**