achieve
physical therapy & sports performance

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.

UNDERSTANDING THE TYPE OF INFORMATION WE HAVE

We receive information about you during your first visit with us, including your name, date of birth, gender, ways to contact you, your social security number, financial information, insurance information and other personal information. We also collect information regarding your condition, diagnosis and treatment. Along with collecting this information from you, we also get enrollment and eligibility status from your health insurer and medical information from other health care providers.

OUR PRIVACY COMMITMENT TO YOU

The information we collect about you is private. We are required to give you an idea of our privacy practices. Only those individuals who have both the need and the legal right may view your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment, payment, business operations, and when we are required by law to do so, or for one of the other reasons listed below.

• Treatment: We may use or disclose medical information about you to provide and coordinate your health care. For example, after you initial appointment with us we usually send a letter to your referring physician regarding your treatment. Another letter shall be sent after you have been discharged from our care.

• Payment: Information may be disclosed so that the care you receive can be properly billed and paid for. For example, we may send your health insurer a bill for our services explaining the treatment you received and why.

• Business Operations: We may need to use and disclose information in our business operations. For example, in order to improve activity necessary to run the business (training or for reviewing the quality of care that you and others receive from us).

• Exceptions: For certain kinds of records, your permission may be required, even for release of treatment, payment and business operations. We will provide you with authorization and consent forms for your signature in order for us to release certain information.

• Phone Messages: We may contact you via phone, answering machine or mail to provide you with authorization, referral, and billing information including information regarding other services that may be of interest to you. You may request in writing if you do not wish for this information to be left with a person other than yourself via phone.

• Mailings: We may send birthday cards/postcards (with no mention of your date of birth). We may also mail statements and other documents necessary to conduct business. You may request in writing for all mail to be sent confidentially (enclosed in an envelope).

As required by Law and for other Government Functions: We will release information when required to do so by law or for other government functions, examples of such releases would be for law enforcement, subpoenas or other court orders, for national security purposes, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

• Public Health and Safety: We may use or disclose information about you as necessary to prevent or reduce a serious threat to the health or safety of another person or the public. For example, we will have to disclose information about certain diseases (and immunizations) to public health officials.

• Family and Friends: We may disclose your information to family members, friends or others you identify to the extent it is relevant to their involvement with your care or payment for your care, or to let them know about where you are and your condition.
• After Death: We may disclose your information to coroners or medical examiners and funeral homes after you are deceased.
• With Your Permission: If you provide us permission in writing, we may use and disclose your personal information for the purposes you list. If you give us permission, you have the right to change your mind and revoke it, but this must be in writing. We cannot take back any uses or discloses already made with your permission.
Our use and disclosure of your personal health information must comply not only with federal privacy regulations but also with applicable Indiana's law. Indiana's law provides different protection to your personal health information. For example, Indiana provides extra protection for minors; we must adhere to the more stringent state privacy protections. We also follow HITECH regulations. While we do implement the use of mobile computing devices we follow recommended security procedures.

PATIENT RIGHTS
You have the following rights regarding the health information we have about you. Your requests must be made in writing to us at:
Achieve Physical Therapy and Sports Performance, LLC
PO Box 628
Angola, IN, 46703
We are committed to ensuring that you receive information regarding your rights as a patient here at Achieve Physical Therapy and Sports Performance.
• Your Right to Inspect and Copy: In most cases, you have the right to look at or receive copies of your medical records upon signing a Medical Record Release form, and in some cases paying a fee if we need to retrieve such records from storage. Please call ahead to ensure that we have your records available for you.
• Your Right to Amend: You may request us to modify your records if you feel the records are not correct. We may deny your request for certain reasons, but we must provide in writing to you the reason for our denial.
• Your Right to a List of Disclosures: You have the right to ask for a list of certain disclosures made after November 5, 2009. This list will include the times that information was disclosed for treatment, payment, or health care operations. The list will include information provided directly to you or your family, or information that was sent with your permission. It will include information released without your name or other date that would identify you.
• Your Right to Request Restrictions on Our Use or Disclosure of Information: You can ask for limits on how your information is used or disclosed. We are not required to agree to such a request, but may if we believe it is reasonable to do so.
• Your Right to Request Confidential Communications: You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your college address instead of your home address or you may ask that we treat you in a room other than the main treatment area. We will do our best to accommodate such a request.

CHANGES IN THIS NOTICE
We reserve the right to revise this notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. If the changes are material, a new notice with be posted.

HOW TO USE THESE RIGHTS UNDER THIS NOTICE
If you want to exercise your rights under this notice or have any questions regarding our privacy issues, you may call or write to us at:
Achieve Physical Therapy and Sports Performance, LLC
PO Box 628
Angola, IN, 46703
Or call the administrative office at:
(260) 665-7000
Complaints to us: if you believe that your privacy rights have been violated or you wish to express your concern regarding non-compliance of our privacy policies and procedures; you may file a complaint by writing to the above address. We will require a written complaint, and may further provide you with an official complaint form that you would need to fill out for our records. You will not be penalized for filing a complaint.

ADDITIONAL INFORMATION
HIPAA is the Health Insurance Portability and Accountability Act of 1996. The revised and updated Privacy Rule portion of HIPAA, including many of the policies described in this notice, went into effect September 15, 2003. You may further research the policies and guidelines of HIPPA via the internet. We will also keep a copy of the final Standards for Privacy of Individually Identifiable Health Information at our front desk for patients to view at their leisure. A copy of this Notice of Privacy Policies will be posted at each of our offices. You will need to read and acknowledge (via signature) that you have received these privacy policies and procedures. A copy of this acknowledgement will be filed in our office.

► **Please list anyone that we can share your information with:**

_____

_____

_____

► **Please circle your answer:**

May we leave a message on the phone numbers you provided? **YES** or **NO**

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge receipt and understanding of Achieve Physical Therapy and Sports Performance notice of Privacy Practices.

Patient name (please print)_____

Signature_____

Date_____

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Consent Form

I, the undersigned, a patient at Achieve Physical Therapy and Sports Performance, LLC, do hereby authorize Emily Watkins, PT, or any of the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. Furthermore, I understand that Achieve Physical Therapy and Sports Performance will prepare insurance forms and will bill my insurance company directly only as a courtesy. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Deductibles/Percentage pays and/or Co-Payments

Co-payments are to be paid AT TIME OF SERVICE, unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the date on the invoice. Patients are to keep payments current. In order to receive a discount with a cash pay visit you must pay on the day of service.

Cancellation/No-Show Policy

I understand that cancellations should be made the day prior to the day of my scheduled appointment(s), unless extenuating circumstances prevent my ability to give notice.

If I have not given 24 hours notice for three appointments in a three week time period I will be limited to scheduling only one appointment per week. The staff of Achieve Physical Therapy and Sports Performance have the right to judge the appropriateness of this policy on a case by case basis.

By signing below you are agreeing to all the above terms and conditions.

_____ _____

Patient or Legal Guardian's Signature Date