HIPPA Notice of Privacy Practices

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

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/18/2014, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

Your protected health information may be used and disclosed by your physical therapist, our clinic staff and others outside our clinic that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physical therapy practice and any other uses required by law.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You Have the Right to Inspect and Copy Your Protected Health Information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You Have the Right to Request a Restriction of Your Protected Health Information. This means you may ask us not to use or disclose any part of your protected health information that is subject to law that prohibits access to protected health information.

This also means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must states the specific restriction requested and to whom you want the restriction to apply.

You Have the Right to Request Confidential Communications from Us by Alternative Means or at an Alternative Location. You have the Right to Obtain a Paper Copy of this Notice from Us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically. Any form of electronic communication is vulnerable to breech by means of the communication and by participating in electronic transfer of information you authorize your protected health information to be sent.

You Have the Right to Have Your Therapist Amend Your Protected Health Information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You Have the Right to Receive an Accounting of Certain Disclosures We Have Made, if any, of Your Protected Health Information.

Complaints: If you believe Van Dusen Physical Therapy has violated your privacy rights, you may make a complaint to Shawna Van Dusen (530) 632-1280. We will not retaliate against you for filing a complaint. We appreciate you bringing up any incident in question in order for us to investigate and correct or preserve the occurrence in question.

We are required by law to maintain the privacy of, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with Shawna Van Dusen (530) 632-1280 or Shelbi Vergara (916) 224-1785.

VAN DUSEN *Physical Therapy, Inc.* **INTAKE FORM**

Date: _____ Patient Last Name: _____ **First Name:** _____ **MI:** ____

Date of Birth: _____/_____/_____ **Sex:** Male / Female **Marital Status:** Married / Single / Widow / Other

Primary Address:_____ City: _____ State: ____ Zip: _____

Primary Phone: _____ **Cell / Home** 2nd Phone: _____ **Cell / Home / Work**

Would you like to receive a text message from us to remind you of your appointment? YES / NO

SSN: _____ - _____ - _____ Nickname: _____ Email: _____

Occupation: _____ Employer: _____ Retired / Student / Self / Other

How did you hear about us? Doctor / Friend or Family / Social Media / Web Browser / Other: _____

Emergency Contact: Name: _____ Phone: _____ Relation: _____

IF MINOR: Responsible Party: _____ Relation: _____ Phone: _____

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Which Payment Method are you using for Physical Therapy:

_____ **Cash Pay**

_____ **Direct Access (No Referral Required – 12 Visit Max – Qualified Insurance Plans Only)**

_____ **Worker's Comp (Authorization Required)**

_____ **TriCare(HNFS) / TriWest(VA) *** REQUIRED: Sponsor SSN: _____**

_____ **Insurance with Referral – Referring Doctor: _____**

INSURANCE INFORMATION:

Primary Insurance: Member/ Subscriber ID: _____ Group: _____

Primary Insured Name: _____ Relation: _____ Date of Birth: _____

Address (if different then above): _____

2nd Insurance: Member/ Subscriber ID: _____ Group: _____

Insured Name: _____ Relation: _____ Date of Birth: _____

Address (if different then above): _____

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Reason for Physical Therapy: Injured Area or Medical Reason _____ OnSet Date: _____

_____ Fall _____ Sports Injury _____ Chronic Condition _____***Surgery** _____ **** Auto Accident**

_____ Employment Injury/Work Comp _____ Other (List Reason): _____

**** For Surgery:*** **Date of Surgery: _____ Facility/Doctor:_____**

***** For Auto Accident (NO LIENS)*** **Date of Accident: _____(Additional Form Required)**

VAN DUSEN *Physical Therapy, Inc.* **MEDICAL INFORMATION**

Have you been to another physical therapist for this injury / medical condition this year? **Yes / No**

If yes, how many visits? _____ (This may affect allowed visits based upon your insurance coverage)

Have you had any Chiropractor visits in the current year for any reason? **Yes / No**

If yes, are you still seeing a Chiropractor? **Yes / No**

If yes, visits this year? _____ (This may affect allowed visits based upon your insurance coverage)

Did you have Home Health Care for this referral/surgery? **Yes / No**

If yes, Discharge Date: _____ (Must have discharge notice to start Outpatient treatment)

Is this referral due to an auto accident? **Yes / No** If yes, who is "At Fault"? _____

Have you had an MRI/X-Ray for the injury or medical condition you are being seen for? **Yes / No**

If yes, Facility Name: _____ Date Completed:_____

Current Medication: (A copy of your medication list can be provided, just write "See attached")

_____

_____

_____

Allergies:

_____

_____

Ailments that you have or have had in the past or present:

____ Parkinson's ____Fibromyalgia ____ Stroke ____ Osteoporosis

____ Heart Trouble ____ Pacemaker ____Diabetes 1 ____ Diabetes 2

____ Anemia ____ Hepatitis C ____ Tuberculosis ____ Epilepsy ____ Asthma

____ History of Cancer ____ High Blood Pressure ____ Traumatic Brain Injury

Past Surgeries/Major Injuries	**Year**	**Hospital/Facility**	**Physician**

VAN DUSEN *Physical Therapy, Inc.* **Policy & Financial Agreement**

PLEASE **READ** AND **INITIAL ALL POLICIES**

____ ***CONSENT TO TREAT*:** I understand that by initialing, I am giving permission for evaluation and treatment by VDPT and that I have the right to refuse any procedure after having the risks and benefits explained to me.

____ ***COPAYS & DEDUCTIBLE*:** I understand that co-pays are due at the time of my appointment and that I am responsible for this payment each and every visit. I also understand that if I have a remaining balance due to deductible or unpaid copays I will receive a billing statement from Van Dusen Physical Therapy and that it is my responsibility to pay upon receipt.

____ ***FINANCIAL RESPONSIBILITY & INSURANCE COVERAGE:*** **ALL** charges, even those not paid by my insurance are my responsibility to pay directly to VDPT. **It is my responsibility to contact my insurance to verify benefits for physical therapy.** I understand that having insurance does not guarantee they will cover or pay for services rendered.

_____***CHANGE IN INSURANCE POLICY:*** I also understand that I must immediately inform VDPT of **ANY** changes to my insurance policy and that neglecting to do so can result in full payment for each visit.

____ ***CANCELLATIONS POLICY:*** I understand that I can be charged a **$50 fee if I fail to show up to my scheduled appointment and I do not give 24 hour notice prior to my appointment time**. This amount is due before I return to my next appointment.

____ ***THREE (3) STRIKE POLICY***: I understand that if I cancel or miss more than 3 scheduled appointments for any reason, VDPT has the right to cancel any future appointments. I understand this does not mean my therapy is terminated, just that I must call on any given day to see if there is an appointment available for me to come in on that day.

____ ***ASSIGNMENT OF BENEFITS:*** I hereby authorize VDPT to furnish information to my insurance carrier(s) concerning my treatment and hereby assign to the Therapist(s) all payments for services rendered.

____ ***MEDICAL AUTHORIZATION*:** I hereby authorize release of any and all necessary medical records to VDPT. In addition, I also consent to the release of my health care records for review by my insurance company or any necessary audits within VDPT.

_____ ***HIPPA (NOTICE OF PRIVACY PRACTICE)*:** I acknowledge that VDPT has offered or supplied me with a copy of their HIPPA Notice of Privacy Practice regarding policies and procedures concerning my Protected Health Information (PHI). I agree to release authorization to VDPT to use my PHI as deemed necessary for treatment, billing and the purposed mentioned in this notice.

I, _____, have read and agree to the above terms and conditions.
(Print Patient Name)

Date: _____ Patient Signature: _____

If MINOR, Parent/Guardian Signature: _____