Welcome to: EAST MOUNTAIN PHYSICAL THERAPY

Although our office staff will file claims with your insurance, it is possible that your insurance may not cover your entire bill. It remains your responsibility to ensure payment of your bill. Please provide us with the following information so we can process your claim:

Patient Information:

_____ Sex: Male Female

Last Name First Name Middle Name

Date of Birth:_____ Social Security #_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Mailing Address:_____ City:_____ Zip:_____

Physical Address (REQUIRED for Treatment):_____

Employer:_____ Phone:_____ Occupation:_____

Referring Physician:_____ Last Seen:_____ Next Visit:_____

Responsible Party (if other than patient):

_____ _____

Last Name First Name MI Relationship to Patient

Date of Birth:_____ Social Security #:_____ Phone:_____

Mailing Address:_____ City:_____ Zip:_____

Physical Address:_____ City:_____ Zip:_____

Employer:_____ Phone:_____

Insurance Information: **(Please provide us with a copy of your insurance card)**

Are you being treated as a result of an accident? _____Yes _____No

Describe the accident:_____

_____ Date of Accident:_____

Do you have an attorney handling this case?_____Yes _____No

Attorney Information:

Name:_____ Address:_____ Phone:_____

Are you currently receiving home health care?_____Yes _____No

Agency Name:_____

Consent for Physical Therapy Treatment and Acceptance of Financial Responsibility:

I am aware of the services provided by East Mountain Physical Therapy and hereby consent to said services. I authorize East Mountain Physical Therapy to release any information necessary to process this claim. I authorize any physician, hospital, medical attendant and others to provide East Mountain Physical Therapy with any and all medical information they may request in order to provide treatment. I authorize payment of medical benefits to East Mountain Physical Therapy for services rendered. I accept ultimate responsibility for payment of my bill, including late fees, interest, and attorney/court collection fees.

Appointment Confirmation Messages

___I give permission for East Mountain Physical Therapy to leave a reminder message on my telephone concerning the date/time of my appointments.

___ I do NOT give permission for East Mountain Physical Therapy to leave a reminder message on my telephone concerning the date/time of my appointments.

_____ _____

Patient or Guardian (if patient is a minor) Signature Date

EAST MOUNTAIN PHYSICAL THERAPY

Patient Medical Information

Current Medications: (if many, please provide us with a list) Height _____

Weight_____

Do you or have you had any of the following?

___ Joint Pains	___ Tire Easily	___ Diabetes	___ High Blood Pressure
___ Muscle Aches	___ Heel Pains	___ Heart Condition	___ Lips or Nails turn Blue
___ Arthritis	___ Chest Pain	___ Obesity	___ Heart Palpation/Fluttering
___ Asthma	___ Leg Pains	___ Shortness of Breath	___ Emphysema Bronchitis
___ Backache	___ Lung Disease	___ Pain or Stiffness (Neck)	___ Limitation of Motion
___ Neuropathy	___ Fibromyalgia	___ Chronic Pain	___ Numbness

___ Allergies _____ Other Diseases _____

___ Cancer (if so, what kind) _____Birth Defects or Abnormalities _____

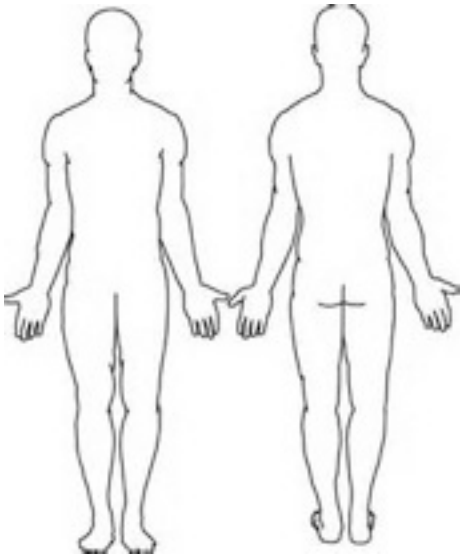
___ Tobacco: __ packs per (day/week) ___ Alcohol: __ drinks per (day/week) __Recreational Drugs _____

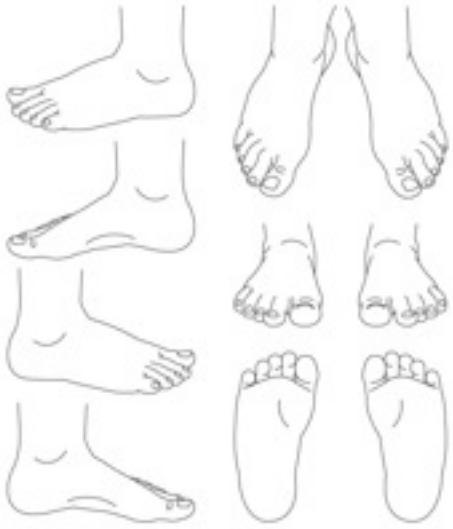
Operations & (dates) _____

What makes your pain worse? _____What helps relieves your pain? _____

Do you have an attorney representing you for the problem(s) that we will be seeing you for? ___yes ___no

Please indicate where your pain is located below:





Patient Name: Date:

EAST MOUNTAIN PHYSICAL THERAPY

Cancellation/No-Show Policy

We recognize and respect your time as being very valuable and will make every effort to begin your treatment promptly at your scheduled appointment time. Our schedules are very full, and we often call in additional staff to help based on the number of patients we have scheduled. Therefore, it is EXTREMELY important that you call us if you are unable to attend your scheduled therapy appointment or if you will be late. We often have patients on a waiting list who we can call to come in your place.

1. If you no-show (do not show without calling to cancel) more than 2 times or cancel your appointments regularly, we will ask you to consider whether or not this is the best time for you to be coming to physical therapy. Because these appointment times are very coveted, we will ask that you move to a waiting list position and call us on the morning you would like to come in. If we have an opening, we will fit you in.

2. Thank you in advance for your cooperation and understanding. Please call the clinic where you are being seen (phone numbers are on the back of each appointment card) as soon as you know you need to cancel or re-schedule your appointment. We check our messages frequently (including after hours) and really appreciate any advance notice of a cancellation.

3. **** <u>NEW POLICY EFFECTIVE OCTOBER 15, 2016</u> ** IF YOU CANCEL WITH LESS THAN 24 HOURS NOTICE (OR NO- SHOW) AND WE ARE UNABLE TO FILL YOUR APPOINTMENT, YOU MAY BE RESPONSIBLE FOR A $20 CANCELLATION FEE.**

We will be contacting you to confirm your appointments. Please indicate your preferred methods of communication (the best way to reach you) below (ranked from 1-3.)
NOTE: We do not share your contact information!

___Phone Message at Cell # _____
___Phone Message at Home # _____
___Text Message: #_____(must be a cell phone)

Patient Signature_____ Date_____

Parent/Guardian_____ Date _____

Notice of Protected Health Information Practices (Privacy Policy)

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.

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), **EAST MOUNTAIN PHYSICAL THERAPY** ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies ad procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

    a. **Treatment**. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.

    b. **Payment**. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

    c. **Health Care Operations**. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. **Uses and Disclosures With Patient Authorization**. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object**. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

    a. **Uses and Disclosures Required by Law**. We will disclose your health information when required to do so by law.

    b. **Public Health Activities**. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

    c. **Abuse and Neglect**. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

    d. **Regulatory Agencies**. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

    e. **Judicial and Administrative Proceedings**. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

    f. **Law Enforcement Purposes**. We may disclose your health information to law enforcement officials when required to do so by law.

    g. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

    h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

    i. **Threats to Health and Safety**. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

    j. **Military/Veterans**. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. **Workers' Compensation**. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. **Marketing**. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.

m. **Appointment Reminders**. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. **Other Uses and Disclosures**. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. **Uses and Disclosures to Business Associates**. With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information**. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.

2. **Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. **Right to Verbally Object**. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. **Right to Seek an Amendment of Your Health Information**. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. **Right to an Accounting of Disclosure of Your Health information**. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. **Right to Confidential Communications**. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. **When Authorizations are Required**. An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.

8. **Right to Revoke Your Authorization**. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

9. **Right to be Notified Following a Breach of Your Information.** If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.

10. **Right to Receive Copy of this Notice**. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at 505-286-3678. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact our Compliance Officer at 505-286-3678. All complaints must be submitted to the Practice in writing at 12127 B-3 N. HWY 14, CEDAR CREST, NM 87008. There will be no retaliation for filing a complaint.

Effective Date

The effective date of this Notice is 9/23/13.

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by EAST MOUNTAIN PHYSICAL THERAPY (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 12127 B-3 N. HWY 14, CEDAR CREST, NM 87008 Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

   _____

   _____

   _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable
_____Other (explain) _____

_____ _____
Signature of Authorized Practice Representative Date

EAST MOUNTAIN PHYSICAL THERAPY

Insurance Benefit Verification Policy

Our front office staff will make every effort to obtain accurate information about your physical/occupational therapy benefits from your insurance company prior to your first visit. However, we are sometimes given wrong information.

Please be sure to contact your insurance company and/or review your policy to ensure that you are aware of your financial responsibility.

If we discover that we have overcharged you for your portion of the therapy, we will promptly refund the money to you. If your insurance company pays LESS than we were originally told, you will be responsible for additional co-insurance/ deductible amounts per your contract with your insurance company.

In the event that we verify eligibility and later discover that you do not have coverage for physical/occupational therapy, you will be responsible for payment. Our self-pay rate is $100/visit for the initial evaluation and $75/visit for each subsequent visit.

Patient/Responsible Party Signature:_____

Date:_____

EAST MOUNTAIN PHYSICAL THERAPY

FINANCIAL POLICY - EXAMPLE

Your policy requires you to pay:

____ Deductible (We will collect $100 at the initial evaluation and $75/visit thereafter. It can take 30 days for us to receive payment from your insurance company. Once we determine how the claim was processed, we will know the exact amount applied toward deductible for each visit. At that point we will either request additional payment, or refund you if overpaid. In most cases, you will not receive a refund - unless your deductible was met when other claims were processed.)

___ Co-insurance (a percentage of what is paid for each visit.) We *estimate* this amount but are unable to know for sure what you owe until the claim processes. This is because your therapist will bill for different codes each visit, depending on which treatments were given. It is possible that you will owe more than we collect. If we have collected more than you owe, we will reduce your co-insurance each visit, or issue you a refund. Again, we don't know the exact amount until your claim processes. The processing time varies depending on insurance.

If you have any questions or concerns, we will be happy to have a billing manager discuss your situation in person or by phone.