Endless Possibilities Physical Therapy, LLC

NOTICE OF PATIENT INFORMATION PRACTICES

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

ENDLESS POSSIBILITIES PHYSICAL THERAPY, LLC'S LEGAL DUTY

Endless Possibilities 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

Endless Possibilities Physical Therapy, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Endless Possibilities Physical Therapy, LLC may use your personal health information to contact you to provide appointment reminders, or information about treatment or other health related information pertaining to overall care.

Endless Possibilities Physical Therapy, LLC 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, Endless Possibilities Physical Therapy LLC'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.

Endless Possibilities Physical Therapy, LLC may change its policy at any time. When changes are made, a new Notice of Information Practices will be 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.

ENDLESS POSSIBILITIES
PHYSICAL THERAPY, LLC

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 you records. You also have the right to request a list of instances here 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 authorize by you, when required by law or in emergency circumstances. Endless Possibilities Physical Therapy, LLC 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 Endless Possibilities Physical Therapy, LLC 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. You may also send a written complaint to the US Dept. of Health and Human Services.

ENDLESS POSSIBILITIES
PHYSICAL THERAPY, LLC

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Endless Possibilities Physical Therapy LLC's Notice of Information Practices. I understand that Endless Possibilities Physical Therapy LLC 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 Endless Possibilities Physical Therapy will consider requests for restrictions 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 Endless Possibilities Physical Therapy'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.

_____

Patient Name

_____

Signature of Parent/Guardian

_____

Date

ENDLESS POSSIBILITIES
PHYSICAL THERAPY, LLC

Endless Possibilities Physical Therapy, LLC

Intake Form

General Information

Sex: Male/Female Child's DOB: _____
Parent/Guardian Name(s): _____
Address: _____
City: _____ State: _____Zip: _____
Home # :_____ Cell#: _____
Emergency Contact Name/Relation: _____
Phone # :_____

Referral Information

- **You are <u>required to inform us of any changes</u> in your child's physician and insurance immediately**

Referring Physician: _____
Phone # :_____ Fax #: _____
Address: _____
City: _____ State: _____ Zip: _____

Insurance Information

<u>Primary</u>: _____Policy Holder: _____
ID Number: _____Group Number_____
<u>Secondary</u>: _____ Policy Holder: _____
ID Number: _____ Group Number: _____

I, _____(guardian), will allow the following use of communication:

Receive billing/communication statement via Email: Yes ___ No___ Email: _____
Receive billing messages/inquiries via Text: Yes __ No___ Text Number:_____
Receive messages from my child's therapists via Email: Yes__ No___ via Text: Yes___ No ___

ENDLESS POSSIBILITIES
PHYSICAL THERAPY, LLC

Family/Social History:
Child lives with □ Biological Parent(s) □ Foster Parent □ Other:
_____

Birth History:
My Child was born:
□ Full Term □ Early? How many weeks?_____

Developmental History:
Does your child have delays in development? □ No □ Yes
Explain: _____

My child receives:
□ **Physical Therapy** □ **Occupational Therapy** □ **Speech Therapy**

Does your Child require special assistance (nurse) or adaptive equipment (Wheelchair, braces, etc.)? □ No □ Yes
Explain:_____

Medications:
_____

Allergies:
_____

List any medical conditions your child has that may require special care or precautions:
_____
_____
_____

Past Medical History (include hospitalizations, surgeries, bone/joint, cardiac, lung/respiratory, GI, vision, hearing, neurological,etc):_____
_____

Signature of Parent/Guardian: _____

Date: _____

Form completed by (print name):

_____

ENDLESS POSSIBILITIES
PHYSICAL THERAPY, LLC

Consent for Care

Consent for Care: I give Endless Possibilities Physical Therapy, LLC permission to evaluate and treat my child as prescribed by my child's physician and/or recommended by my therapist. I understand that I have the right to ask any questions prior to my child receiving treatment.

Other Professionals involved in child's care: I am responsible for informing Endless Possibilities Physical Therapy, LLC immediately of any changes in services and/or other professional involved in my child's care. For example, physicians, other therapists, CAP workers, etc.

Consent for payment: I give Endless Possibilities Physical Therapy consent to bill my insurance company/provider for services rendered. As courtesy to our patients, we verify and file your insurance; however we cannot guarantee payment. *Our in-network status does not guarantee that services will be covered by your insurance plan. It is important that you understand your individual benefits as coverage for therapy services depends upon your specific plan/policy.*

I understand that I am responsible for the percentage and/or deductible not covered by my insurance company. If insurance information is not available, payment in full is due at the time of visit unless other arrangements are made.

Co-payments: I understand that any applicable co-payments required by my insurance are paid at the time of the visit.

Therapy Records: I understand that there is a $10.00 fee minimum for a copy of my child's therapy records to cover supplies and time to copy. (Therapy records that are greater than 15 pages will be charged an extra $.50 per page).

Insurance: I am responsible for informing Endless Possibilities Physical Therapy, LLC of any changes in my child's insurance coverage.

Personal health information: I am aware that my child's information may be shared for the purpose of treatment, payment and health care operations.

ENDLESS POSSIBILITIES
PHYSICAL THERAPY, LLC

Photo/video: I understand that any photos or videos of my child may be used to document my child's treatment, progress and care and for no other purpose unless I specifically grant consent.

Attendance/illness: I am aware if my child misses 2 or more appointments without good cause, Endless Possibilities Physical Therapy, LLC will have the option of discharging my child from further care. **Please call to cancel if your child is sick and/or contagious.**

*** Health and safety:** I understand that Endless Possibilities Physical Therapy, LLC is responsible for reporting any abusive behavior, unsafe or unclean conditions, drug/alcohol use, and use/display of weapons.

I have read, understand and accept the above statements.

_____ _____

Parent/Guardian Signature Date

Please feel free to call 412-865-7484 with any questions.

ENDLESS POSSIBILITIES
PHYSICAL THERAPY, LLC

Endless Possibilities Physical Therapy, LLC

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. At any time you may add or remove authorized designees in writing.

Authorized Designees:

Doctor Name: _____

CDSA Name: _____

Case Manager Name: _____

Daycare/Preschool Name: _____

Teacher(s) Name(s): _____

Other Therapist(s) Name(s): _____

Equipment and/or Bracing Representative: Name(s): _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient/Child's Name: _____

Signature of Parent/Guardian: _____

Date: _____