_____

Name: Last: First: Middle Initial: Jr, III, etc:

_____

Date of Birth: Age: Male/Female:

_____

(Physical Address) Street: City: State: Zip Code:

_____

(Mailing Address) Street/PO Box: City: State: Zip Code:

_____

Email address:

May we email you with limited patient related information at the email address you provided above? (Please circle one) Yes No

Cell Phone: (____)-_____-_____

May we leave a message with limited patient related information at the **cell** number you provided above? (Please circle one) Yes No

Home Phone: (____)-_____-_____

May we leave a message with limited patient related information at the **home** number you provided above? (Please circle one) Yes No

Is the reason you are seeking physical therapy services due to a **work related injury**?Yes No

Authorization for Treatment:

I hereby give authorization for performance of such rehabilitation procedures, as permitted by California Statutes under the appropriate scope of practice, which are, in the judgement of my Physical Therapist, deemed necessary.

Initials_____

Certification of Information:

I certify the information I have provided Summit Physical Therapy, is accurate and truthful.

Initials_____

Assignment of Insurance Benefits:

I authorize that the payment of my insurance benefits be made directly to Summit Physical Therapy for any services that are reimbursable by Medicare or my secondary insurance carrier, if I have one.

Initials_____

Guarantee of Payment:

I understand that all payments designated as “the patient’s responsibility” such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed “my responsibility” by the billing statement due date.

Initials_____

Medicare Beneficiaries:

Summit Physical Therapy is a Medicare Part B (outpatient) provider **only** (we have no contract arrangements with any of the private insurance carriers). We will bill/submit claims to Medicare for your physical therapy Part B services that are provided in our facility. The 2017 annual per beneficiary therapy cap is **$1980 for physical therapy and speech language**

pathology services combined. There is a separate $1980 amount allotted for occupational therapy services.[1] Medicare will pay **80%** of the ***allowed charges*** for your physical therapy services **once your annual deductible has been met.** You, as the Medicare Beneficiary, are responsible for the remaining **20%** of these allowed charges. The "allowed charges" for all physical therapy services are pre-determined by Medicare. If you have not met your 2017 annual deductible of $109 - $134, it is possible, that ***you will pay this amount*** to Summit Physical Therapy before your Part B benefits take effect.

If you are set up as an automatic crossover with Medicare (meaning: once Medicare receives the claims from Summit Physical Therapy, they will automatically forward the 20% Beneficiary Responsibility for your PT services to your Secondary Insurance (if you have one)). Here are some things you need to understand:

- Summit Physical Therapy ***has not*** contracted with any ***private insurance companies***. Your Secondary Insurance physical therapy benefit coverage may be specifically designated for a ***physical therapy contracted provider*** only (**which Summit Physical Therapy is not)**. As such, your Secondary Insurance may reject the **20% Beneficiary Responsibility for your PT services** as a non-covered benefit (this does not happen often, but it can happen). In this scenario, this means that you, as the Medicare beneficiary, ***will be responsible*** for the 20% Beneficiary Responsibility charges in full. In this scenario, Summit Physical Therapy will alert you of this remaining balance which is to be paid, by you, to Summit Physical Therapy.

  Initials_____

- Another possible scenario is that your Secondary Insurance may only ***partially*** cover the 20% Beneficiary Responsibility. In this scenario, Summit Physical Therapy will alert you of the remaining balance, which has not been covered by your Secondary Insurance, which is to be paid, by you, to Summit Physical Therapy.

  Initials_____

- If you do not have a Secondary Insurance, you are responsible for the 20% Medicare Beneficiary Responsibility in full (after Medicare has

processed/paid their 80% of the allowed PT services). In this scenario, Summit Physical Therapy will alert you of this balance which is to be paid, by you, to Summit Physical Therapy.

Initials_____

- If you **<u>are not set</u>** up as an automatic crossover with Medicare, Summit Physical Therapy **<u>is not</u>** set up to **<u>separately</u>** bill your secondary insurance. In this case, Summit Physical Therapy will collect the 20% responsibility from you after your claim has processed/paid by Medicare.

Initials_____

<u>PLEASE NOTE:</u> ***It is a <u>violation</u> of Medicare policy*** for Summit Physical Therapy to ***discount or waive*** the Medicare beneficiary 20% responsibility. Furthermore, Summit Physical Therapy ***<u>does not verify your secondary insurance benefits</u>***. It is ***<u>your responsibility</u>*** to know and understand all of your insurance benefits for physical therapy services (for both Medicare and Secondary Insurances (if applicable)).

As a Medicare Beneficiary with or without Secondary Insurance Coverage, I understand the above regarding how Summit Physical Therapy will bill for my physical therapy services. I agree to pay for any physical therapy services that are ultimately determined to be my financial responsibility by Medicare and/or my Secondary Insurance (if I have one).

_____

Medicare Beneficiary/POA Printed Name & Signature: Date:

<u>Acknowledgement of Receipt of Notice of Privacy Practices:</u>

My signature below indicates that I have been given the Notice of Privacy Practices for Summit Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Summit Physical Therapy to release any of my protected healthcare information.

Initials_____

Cancellation and No Show Policy:

Summit Physical Therapy provides direct, one-on-one, physical therapy care, provided by a fellowship trained, orthopedic certified, Doctor of Physical Therapy at **every** scheduled appointment. Time is blocked off and held on the schedule for your appointment.

As such, Summit Physical Therapy **requires** a full, 24 hour advance notice (phone call or text only) for **any** appointment cancellation.

If you are unable to give a **full, 24 hour advance notice, or you do not show for your scheduled appointment, you will be charged 100% of the service fee ($90) which will be collected from you** at your next scheduled appointment (it is not billable to your insurance).

Failure to pay for your late cancellation or missed appointment at your next appointment will result in you being removed from the schedule for any further appointments until the fee has been collected.

I, _____ have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

Initials_____

Athletic Waiver and Release of Liability:

In consideration of being allowed to use the facilities of Snowcreek Athletic Club and participate in offered programs, classes, activities or events, the undersigned acknowledges, appreciates and agrees that:

- The risk of injury from the use of Snowcreek Athletic Club facilities and participation in offered activities, programs, and events is significant, including the potential for permanent disability and death, and while particular rules, equipment and personal discipline may reduce this risk, the risk of serious injury exists, and

- **I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS**, both the known and assume full responsibility for the damages following any such injury, permanent disability or death,
- and I willingly agree to comply with the stated and customary terms and conditions for participation. If, however, I observe any unusual significant hazard during my presence or participation and bring such to the attention of the nearest official immediately: and,
- I for myself and on behalf of my heirs, assigns, personal representatives and next of kin, **HEREBY RELEASE AND HOLD HARMLESS <u>SNOWCREEK ATHLETIC CLUB</u>**, their officers, officials, directors, agents, coaches, and other employees, volunteers, or participants, sponsoring agencies, **WITH THE RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, LOSS OR DAMAGE TO PERSONAL PROPERTY.**

  I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT

_____

Printed Name & Signature Date:

<u>FOR PARENTS AND/OR LEGAL GUARDIANS:</u> (NEEDED ONLY IF PARTICIPANT IS UNDER THE AGE OF 18)

This is to certify that I, as parent/guardian with the legal responsibility for this participation, do consent and agree to his/her release as provided above of all the **RELEASERS** and, for myself, heirs, assigns, and next of kin, I release and agree to indemnify the **RELEASEES** from any and all liabilities incident to my minor child's involvement or participation in the activities, programs, classes and events provided above.

_____

Printed Name & Signature Date:

Informed Consent for Physical Therapy Services:

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Summit Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

Initials_____

I have read all of the above. My initials reflect my understanding of, and my agreement with, Summit Physical Therapy's Policies.

_____

Patient/Authorized Representative Printed Name & Signature: Date:

Health Information Privacy Notice

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information.

Please Review This Document Carefully.

About Protected Health Information (PHI).

In this Notice, "we", "our" or "us" means this Summit Physical Therapy and our workforce of employees, contractors and volunteers. "You" and "your" refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information, we call this Protected Health Information---or "PHI". In this Notice, we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information

We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call "health care operations". We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete

list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

1. <u>Treatment</u>

We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optimal care is rendered.

2. <u>Payment Involving a Third Party Payer</u>

After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payer may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

3. <u>Payment Exclusive of a Third Party</u> Payer (fully self-pay)

If you choose to pay for your services, in full, without involving a third party (insurer, employer, etc.) you may request that we do not disclose any information regarding your services for payment purposes.

4. <u>Health Care Operations</u>

We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of actual patients to test them on their skills and knowledge. Other operational uses may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

5. Special Uses

We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

- Update your workers compensation case worker or employer
- Remind you of appointments
- Carry out follow ups on home programs that you have been taught
- Advise you of new or updated services or home supplies (you can choose to opt-out of receiving any notices of this kind)
    - Release equipment and/or supplies to your designee
    - Carry out follow ups on your home programs or discharge planning
    - Advise you of new or updated services or home supplies via telecommunication or via a newsletter (you can choose to opt-out of receiving information of this nature from us)
    - Carry out research that does not directly identify you
- Carry out marketing functions such as providing nominal promotional gifts (you can choose to opt-out of receiving any marketing information or items from us)
- Contact you regarding fundraising projects that we are engaged in (you can choose to opt-out of any fundraising project notification that we engage in)

6. Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

- If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
- We may use your PHI in an emergency if you are not able to express yourself
- If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research; Summit Physical Therapy will always obtain an authorization from you even though it is 'permitted' without one

Required:

- When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
- For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
- To report neglect, abuse or domestic violence
- To the government regulators or its agents to determine whether we comply with applicable rules and regulations
- In judicial or administrative proceedings such as a response to a valid subpoena
- When properly requested by law enforcement officials or other legal requirements such as reporting gunshot wounds
- To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
- Deemed necessary by appropriate military command authorities if you are in the Armed Forces
- In connection with certain types of organ donor programs
- Stricter Requirement That We Will Follow; if California passes privacy regulations that are more stringent than federal privacy laws we will comply with those laws upon their effective date

7. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and

limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

8. <u>Your Privacy Rights and How to Exercise Them</u>

You have specific rights under our federally required privacy program. Each of them is summarized below:

- **<u>Your Right to Request Limited Use or Disclosure</u>**

  You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right

- **<u>Your Right to Confidential Communication</u>**

  You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing

- **<u>Your Right to Inspect and Copy Your PHI</u>**

  You have the right to inspect and copy your PHI. If we maintain our records in paper, that will be the format utilized; however if we maintain our records electronically you have the right to review and/or have copies made in an electronic format. Should we decline, we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request to inspect your records within five (5) working days and we must provide you with a copy of your records within fifteen (15) days from receipt of a written request; we may charge reasonable fees for copying and labor time related to copying and we may

require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.

- **Your Right to Revoke Your Authorization**
  If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope

- **Your Right to Amend Your PHI**
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that write. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record

- **Your Right to Know Who Else Sees your PHI**
  You have the right to request an accounting of certain disclosure that we have made over the past six years. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually. We have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.

- **You Have a Right to Complain**

  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us by contacting our HIPAA officer noted in Section 10, or to the:

  Office for Civil Rights, Region IX
  U.S. Department of Health and Human Services
  50 United Nations Plaza, Room 322

San Francisco, CA 94102
Voice Phone (415) 437-8310
Fax (415) 437-8329
TDD (415) 437-8311

We will not retaliate against you if you file a complaint about us. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

9. Some of Our Privacy Obligations and How We Perform Them

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind

If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

10. Contact Information

If you have questions about this Notice, or if you have a complaint or concern, please contact:

Name: Bryan Dennison
Address: PO Box 1549
Mammoth Lakes, CA 93546
Phone: (760) 709-6161

11. Effective Date:

This revised notice takes effect on October 10, 2014.


Summit
Physical Therapy