PRIVACY STATEMENT

ADDITIONAL USES FOR INFORMATION

APPOINTMENT REMINDER
Your health information may be used by our staff to send you appointment reminders.

INFORMATION ABOUT TREATMENTS
Your health information may be used to send you information on the treatment and management of your condition or a new technology that you may find to be of interest. We may also send you information describing other health related goods that may interest you.

YOUR HEALTH INFORMATION RIGHTS

- You have certain rights under the federal privacy standards
- The right to request restrictions on the use and disclosure of your health information
- The right to receive confidential communication concerning your medical condition and treatment.
- The right to copy and inspect your medical information.
- The right to receive an accounting of how and to whom your health information has been disclosed.
- The right to amend/ or submit corrections to your health information.
- The right to receive a printed copy of this notice.

OUR HEALTH INFORMATION DUTIES
We are required by law to maintain privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined here.

Our right to revise privacy practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changed in federal and state laws and regulations. The revised polices and practices will be applied to all protected health information that we maintain and will be available at our facility at your request.

Requests to inspect protected health information. As permitted by federal regulations, we require that requests to inspector copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office.

COMPLAINTS
If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact us by send a letter outlining your concerns to:

Performance Sports Physical Therapy
560 Center Road
West Seneca, NY 14224

You may also file a written complaint with the Office of Civil Rights.

PATIENT AGREEMENT FORM

PATIENT'S NAME (please print)_____

As a courtesy to you, we will call and verIfiy your insurance coverage. However, we will not be responsible for incorrect information/authorization given to us by yourself or your insurance representative. Therefore, it is your responsibility to be aware of your own plan and it's condition.

Your are responsible for any deductibles, co-insurance, co-pays, or any other non-covered services per your individual policy. If your policy or plan changes during the time of treatments, you must notify us immediately. ***Failure to do so may result in a balance owed by you.***

If you would like to receive physical therapy services even though your insurance company may not cover such treatment, you may pay privately for them. The current rate is $75.00 for initial evaluation and $50.00 for any follow up treatments. Payment is due prior to treatment being administered unless arrangements have been made otherwise.

If a client/patient fails to show for a scheduled appointment without prior notification, a $20.00 fee will be applied to your account.

INSURANCE COMPANY NAME_____

COVERAGE/BENEFIT_____

_____

_____

_____

I_____, agree to pay_____to Performance Sports Physical Therapy for each visit at the time of the visit to be applied to any deductible and/or coinsurance or copays, unless other arragements have been agreed upon.

I have read and understand the above information.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

PATIENT AUTHORIZATION

PATIENT'S NAME (please print)_____

RELEASE OF INFORMATION & CONSENT FOR TREATMENT

I am aware of my diagnosis and wish to receive treatment at Performance Sports Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Performance Sports Physical Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, and employer, school, related healthcare provider, assignees and/or beneficiaries and all other professional persons as it relates to my treatment.

I authorize Performance Sports Physical Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

ASSIGNMENT OF BENEFITS

I authorize payment directly to Performance Sports Physical Therapy for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practice for Performance Sports Physical Therapy. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

PAYMENT GUARANTEE

I agree to pay Performance Sports Physical Therapy for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for timely collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage.If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself, and a representative of Performance Sports Physical Therapy.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

MEDICARE SECONDARY PAYER (MSP) SCREENING FORM

PERFORMANCE SPORTS PHYSICAL THERAPY

PATIENT'S NAME (please print)_____

MEDICARE # _____ **DATE** _____

1. Are you or your spouse currently employed and covered by a group health plan? **◊ YES | ◊ NO**

IF YES, does your employer employ 20 or more employees? **◊ YES | ◊ NO**
Approximate Number of Employees _____
Name & Address of Employer _____
_____
_____

IF NO, list retirement date:
Patient _____ Spouse _____

2. Is your Medicare entitlement due to...

A. End Stage Renal Disease (ESRD)? **◊ YES | ◊ NO**
IF YES, Date of First Dialysis Treatment _____
Date of Kidney Transplant _____

B. Disability? **◊ YES | ◊ NO**
IF YES, are you considered and active employee? **◊ YES | ◊ NO**
Does your employer employ 100 or more employees? **◊ YES | ◊ NO**
Approximate Number of Employees _____

3. Is this illness or injury due to a work related accident/condition? **◊ YES | ◊ NO**

IF YES, Date of Accident _____ Claim Number _____
Name & Address of WC Plan _____
_____
_____

(Workers' Compensation is primary only for claims related to injuries/illness covered under claim)

4. Is this illness or injury due to an automobile accident? **◊ YES | ◊ NO**

IF YES, Date of Accident _____ Claim Number _____
Name & Address of Auto Insurance _____
_____
_____

(Auto insurance is primary only for claims related to injuries/illness covered under claim)

5A. Do you have coverage through the department of Veteran Affairs? **◊ YES | ◊ NO**

IF YES, Date of Benefits Began _____
Has DVA authorized treatment at our facility? **◊ YES | ◊ NO**

5B. Do you have coverage through the Black Lung Program? **◊ YES | ◊ NO**
(Black Lung is primary only for claims related to Black Lung)

5C. Do you have coverage through any other state agency, not including Medicaid, Medical Assistance or Welfare?
◊ YES | ◊ NO
IF YES, Date of Benefits Began _____

MEDICARE SECONDARY PAYER (MSP) SCREENING FORM

PERFORMANCE SPORTS PHYSICAL THERAPY

PATIENT NAME _____

MEDICARE # _____ **DATE** _____

6. Are you currently receiving services from a Home Health Agency? ◊ **YES** | ◊ **NO**

7. Briefly explain the reason for your visit.

_____
_____
_____
_____
_____

IF YOU OR A SPOUSE ARE CURRENTLY WORKING:

Name of Working Person _____
Date of Birth _____
Relationship to Patient _____

IF THIS TREATMENT IS DUE TO A WORKERS COMPENSATION CLAIM:

Employer _____ Phone _____
Address _____
City _____ State _____ Zip _____

IF THIS TREATMENT IS DUE TO AN AUTO ACCIDENT, NO FAULT INSURANCE CLAIM, OR ANY OTHER MEDICAL COVERAGE:

Insurance Carrier _____ Phone _____
Address _____
City _____ State _____ Zip _____
Group# _____ ID # _____ Claim # _____
Effective Date of Insurance _____ Type of Insurance _____

I have completed this form to the best of my ability. I authorize Performance Sports Physical Therapy to bill the insurance carrier noted above as my primary insurance provider.

SIGNATURE OF PATIENT/REPRESENTATIVE _____

DATE_____

MEDICARE PATIENT THERAPY QUESTIONNAIRE

PERFORMANCE SPORTS PHYSICAL THERAPY

PATIENT'S NAME (please print)_____

DATE OF BIRTH _____ **AGE** _____

Please answer the following questions by selecting YES or NO. If you answer YES to any of the questions, please provide the requested information.

◊ YES | ◊ NO **1.** Have you been discharged from the hospital or Skilled Nursing Facility within the past 30 days?
Date of Discharge _____
Name of Facility _____

◊ YES | ◊ NO **2.** Have you received similar therapy services for ***this problem*** in the past?
Date(s) of Therapy _____
Provider Name _____
Services Provided _____

◊ YES | ◊ NO **3.** Have you received therapy services for ***other problems/conditions*** in the past calendar year?
Problem/Condition _____
Provider Name _____
Services Provided _____

◊ YES | ◊ NO **4.** Are you also receiving Speech and Language Pathology services?
Provider Name _____

◊ YES | ◊ NO **5.** Do you have any conditions that you feel will affect your ability to recover from the problem you are currently receiving therapy for?

◊ YES | ◊ NO **6.** Do you need to use special medical equipment as a result of your current problem?

◊ YES | ◊ NO **7.** Since the onset of this current problem, have you required more assistance from family or friends?

◊ YES | ◊ NO **8.** Is this therapy necessary in order to return to your previous level of independence with daily activities (i.e. Bathing, Dressing, Eating, etc.)

9. At this time, would you rate your health as (check one):
◊ Excellent ◊ Very Good ◊ Fair ◊ Poor

10. What type of home environment do you live in now? (check one)
◊ Private Home ◊ Assisted Living ◊ Other_____
Who do you live with? _____

◊ YES | ◊ NO **11.** Has this current problem resulted in the need to change your living situation?

◊ YES | ◊ NO **12.** Is therapy necessary to return to your previous living situation?
IF YES:

A. What type of home environment do you intend to live in when you complete this therapy?
◊ Private Home ◊ Assisted Living ◊ Other_____
B. Who do you intend to live with when you complete this therapy? _____

SIGNATURE OF PATIENT/REPRESENTATIVE _____

DATE_____