Mobile Physical Therapy
Innovative Therapy Services, LLC

1310 Papin St, Suite 109
Saint Louis MO 63103
Office: 314-558-1385
Fax: 314-558-2600

Notice of Patient Information Practices (HIPAA)

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

OUR LEGAL DUTY

Mobile Physical Therapy is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION

Mobile Physical Therapy uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide. In addition, we may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes. We may disclose your health information to public health, law enforcement, and correctional institutions when we are required to do so by law.

In any other situation, Mobile Physical Therapy will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. You may request a copy of our Notice of Information Practices at anytime. Our HIPAA Compliance Officer is Brad Abrams. He can be reached by calling 314-255-9749.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at anytime. As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment, or other related administrative purposes. You may request in writing that we not use or disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required bylaw, or in an emergency.

CONCERNS AND COMPLAINTS

If you are concerned that Mobile Physical Therapy 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 HIPAA Compliance Officer, Brad Abrams, at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Brad Abrams PT, DPT, GCS
1310 Papin St. Suite 109
Saint Louis, Missouri 63103
314-558-1385 Office
314-558-2600 Fax

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Payment Policy and Consent Form

_____ **PRIMARY INSURANCE**—We will bill your primary insurance and assume payment of insurance benefits is not forthcoming on charges older than 60 days. Charges outstanding for more than sixty days will be due in full from you regardless of the type of insurance involved. Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your insurance benefits. V**erification of benefits by Mobile Physical Therapy is not a guarantee of payment** from your insurance carrier. Secondary insurance will be your responsibility to file and collect.

_____ **MEDICARE**—We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

_____ **SELF PAY**—Please pay the balance in full at the time of service or upon the receipt of a monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Credit cards are accepted for payment on account.

TERMS ARE $_____ PER 25 MINUTE 50 MINUTE VISIT

CANCELLATION POLICY: To maintain appointment times available for all of our patients, there is a cancellation charge of $15.00, *BILLED TO THE PATIENT,* for each instance a patient does not give at least 24-hour cancellation notice.

_____ **By i**nitialing this space this box indicates that the formal office **HIPAA policy and procedures** have been explained to the above-noted patient and that a copy of the policy was provided to the patient.

_____ By initialing this space and my signature below, **I authorize release of imaging studies and/or medical records from any treating provider to Mobile Physical Therapy** as related to my physical therapy evaluation and treatment.

_____ By initialing this space and my signature below, **I hereby authorize release of my medical records from Mobile Physical Therapy to business associates for purposes related directly to procuring additional healthcare services and equipment** as discussed with my therapist.

_____ By initialing this space and my signature below, **I hereby authorize the use of photos or video to be used for documentation or educational purposes.**

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to Mobile Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is there in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (12% annually) for unpaid balances over 30 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

I do hereby consent to such treatment by the authorized personnel of Mobile Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

AUTHORIZED SIGNATURE_____**DATE**_____