Synergy Physical Therapy
Policy Form

Please initial each section, then sign and date the bottom

Consent to Treatment:

I give Synergy Physical Therapy my consent to provide any and all therapy services deemed necessary by the therapist and as recommended by my physician. Upon completion of the initial evaluation the therapist will discuss their findings with me at which point the most appropriate treatment plan will be determined. I understand that prior to treatment and care, the therapist will provide clear and concise information regarding services performed (joint mobilization, stretches, etc…). I understand there are inherit risks involved during the course of treatment (exercise and rehabilitation) including but not limited to muscle cramps, sprains, falling and tripping.

Initials: _____

Cancelation Policy:

I understand that a **24 hour notice** of cancelation is required to avoid **a $25 fee** to be paid at the next scheduled appointment. An appointment with less than 24 hour notice can be rescheduled for the same week, in addition to already scheduled appointments to avoid the cancellation charge.

Initials: _____

Credit and Billing Policy:

As a courtesy to the patient Synergy Physical Therapy will provide an insurance verification to help you understand your insurance benefits and coverage. These benefits are based on what your insurance company provides to Synergy Physical Therapy and may not always be correct. Synergy Physical Therapy is not liable for incorrect verification of benefits provided by your insurance company.

Co-pays are due at time of service or a credit card to be placed on file. Payment plans can be arranged for those who can't afford any balance due with a credit card placed on file. A finance charge **of 12% per month** will be charged to account with 60 days of delinquency. It is the patients' responsibility to keep accounts current. Unpaid accounts will be turned over to collections.

Initials: _____

Authorization for Signature on File and Release of Information:

I authorize Synergy Physical Therapy to affix my name to any and all claims or documents as related to any health benefits due to me. I authorize the release of any information relating to my health claims. A Photostatted copy of this authorization shall be valid as an original.

Initials: _____

Authorization for Assignment of Benefits:

I herby assign all medical benefits to which I'm entitled to the office of Synergy Physical Therapy or I shall be responsible for the unpaid balance. In event payment is made directly to me for services, I recognize the obligation to promptly remit payment to the office. I herby authorize and instruct my insurance company to pay by check and mail directly to Synergy Physical Therapy.

Initials: _____

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Consent for use and Disclosure of Health Information Acknowledgment Form

I have had full opportunity to read the Synergy Physical Therapy Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Synergy Physical Therapy to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. I understand the terms of this notice may change with time and Synergy Physical Therapy will always post the current notice at the clinic, on the website, and will have copies available for distribution.

Patient Name (Printed): _____ **Date:** _____

Patient (or Guardian) Signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice please contact our Privacy Officer, Emily Henriques

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, and/or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose

protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Emily Henriques** at (480) 767-0794 **or email her at Emily@synergyptph.com** for further information about the complaint process.

This notice was published and becomes effective on **01-01-2020**