OPTIMAL REHAB PHYSICAL THERAPY, INC.

DBA KINGSBURG PHYSICAL THERAPY

NOTICE OF PATIENT PRIVACY PRACTICES

This notice is effective on or after January 1, 2024.

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.

LEGAL DUTY OF OPTIMAL REHAB PHYSICAL THERAPY, INC.

Optimal Rehab Physical Therapy, Inc., 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 described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Optimal Rehab Physical Therapy, Inc. uses your personal health information primarily for the treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care we provide. For example, **Optimal Rehab Physical Therapy, Inc**. may also use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Optimal Rehab Physical Therapy, Inc. 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, our policy at **Optimal Rehab Physical Therapy, Inc**. is to obtain your written specific authorization before disclosing your personal health information. If you change your mind after authorizing a use or disclosure of your information you may submit in writing revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of information that occurred before you notified **Optimal Rehab Physical Therapy, Inc.**

Optimal Rehab Physical Therapy, Inc. may change its policy at any time. When changes are made to the Notice of Privacy Practices, we will provide you with a revised notice on your next visit. You may also request an updated copy of our Notice of Privacy Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal information at any time (**$25.00 copying fee**). You have the right to request that we correct any inaccurate or incomplete information in your records. You may also have the right to request a list of instances where we have disclosed your personal health information for any reason 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 authorized by you, when required by law or in emergency circumstances. **Optimal Rehab Physical Therapy, Inc.**will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer at 7405 N. Cedar Ave #103, Fresno, CA. 93720; ph. 559-261-4100. *You will not be penalized for filing a complaint.*

OPTIMAL REHAB PHYSICAL THERAPY, INC.

Patient Information Consent Form

I have read and fully understand the **Optimal Rehab Physical Therapy, Inc.** Notice of Patient Privacy Practices. I acknowledge that I have received a copy of **Optimal Rehab Physical Therapy, Inc.** Notice of personal health information. I understand that **Optimal Rehab Physical Therapy, Inc.** may use or disclose my personal health information for the purpose 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 **Optimal Rehab Physical Therapy, Inc.**. 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 the **Optimal Rehab Physical Therapy, Inc.** Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____(please print)

Patient's Signature: _____Date: _____

This notice is effective on or after January 1, 2024.

OPTIMAL REHAB PHYSICAL THERAPY, INC.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION FROM OPTIMAL REHAB PHYSICAL THERAPY, INC. TO DESIGNATED PERSONS

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient name: _____
First and last name

Date of birth: _____
dd//mm/yyyy

Telephone: _____
(xxx)xxx-xxxx

I, _____(patient - please print) hereby authorize **Optimal Rehab Physical Therapy, Inc** to release **any and all** information about my *health, medical condition, or billing for services* to members of family or other person, as specified below. This includes verbal discussions with the therapy/medical staff and copies of my medical record.

Designated Person

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

Specify limitations (if any) on the use of the information:_____

***Expiration of Authorization**

This authorization becomes effective upon signing and will expire one year from date of signature, **unless** specific expiration date is given: (date)_____.

x_____ x_____

Signature of Patient or Patient's Legal Rep Date

OPTIMAL REHAB PHYSICAL THERAPY, INC.

PATIENT FINANCIAL AGREEMENT

The patient has a large role to play in ensuring that sufficient financial resources are available to maintain the availability of affordable health care services in the community. Our goal is to provide our patients with the highest quality of medical care and customer service.

PAYMENT: All copays and deductibles are due at the time of service. We accept cash, checks, debit, credit cards (Visa and Mastercard only). **As a courtesy to our patients, we will contact your insurance provider to verify your physical therapy coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.**

INSURANCE: We do encourage you to call your insurance company with any specific questions related to your policy's outpatient physical therapy benefits such as deductible, copayment, coinsurance, visit limitation i.e., sharing of outpatient benefits with acupuncture, chiropractic or occupational care, effective annual calendar renewal date, or any pre-authorization requirements.

If you are treated for a work related injury and the industrial carrier denies your claim, we will bill you and your individual insurance, provided we are given correct billing information.

In the event that you do not have medical insurance coverage for physical therapy treatment, full payment will be expected at the time of service. The cost of the initial physical therapy evaluation is **$130.00** and the cost for each follow up visit is **$75.00**. We realize that temporary financial problems may affect the timely payment of your account. If this situation should occur, please contact our billing department immediately to assist you with the management of your account. Overdue accounts may be subject to further collection activity.

Optimal Rehab Physical Therapy, Inc. cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill. Please note: **Optimal Rehab Physical Therapy, Inc.** is not contracted with Medi-Cal and balances that apply to your deductible by your primary insurance will be your responsibility.

CANCELLATION POLICY: Therapist time is reserved for your appointment - if you are unable to keep your appointment, we kindly ask that you provide us with **24-hour** advance notice of cancellation/rescheduling. Failure to give 24-hour advance notice will result in a charge of **$25.00.** Three consecutively missed appointments without notification may subject the patient to discharge from outpatient physical therapy services. In this event, the referring physician and possibly insurance provider will be notified.

I have read and understand the above **Optimal Rehab Physical Therapy, Inc.** Financial Policy, agree to the terms, and understand that I am ultimately responsible for payment of the health care services provided.

_____ _____

Printed Patient Name Printed Name of Guarantor (if applicable)

_____

Signature of Patient (or Guarantor) Date

OPTIMAL REHAB PHYSICAL THERAPY, INC.

Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Sex(circle): Female Male

Birthdate:_____ **Soc.Sec.#:**_____ **Height:**_____ **Wt:**_____

Email Address: _____

Employer: _____ **Phone Number:** _____

Emergency Contact: _____ **Phone Number:** _____

Referring Physician: _____ **Phone Number:** _____

RESPONSIBLE PARTY

Name: _____ **Phone Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Birthdate:_____

MEDICAL HISTORY

- ❑ Osteoarthritis
- ❑ High Blood Pressure
- ❑ Diabetes Mellitus Type 1 / Type 2
- ❑ Allergies : _____
- ❑ Epilepsy
- ❑ Surgical History:_____
- ❑ Previous Therapy:_____
- ❑ Dizziness/Vertigo
- ❑ History Of Cancer:_____
- ❑ Urinary Problems
- ❑ Currently pregnant, # weeks: _____
- ❑ Fracture Or Suspected Fracture
- ❑ Parkinson's
- ❑ Multiple Sclerosis
- ❑ CVA /stroke
- ❑ Other health conditions: _____

MEDICATIONS: (List all current medications):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

I agree that the above information is accurate.

Patient/guardian name (print): _____

Signature: _____ **Date:** _____