



Welcome to Elite Physical Therapy. Your physician has referred you to physical therapy to assist in your healing and recovery. In order for us to most effectively assist you on the road to recovery, the following guidelines and policies have been implemented.

- **Clothing:** For future visits, please wear loose, comfortable clothing, including sneakers.
- **Attendance:** To assist you in your care, consistent and timely attendance to your physical therapy is extremely important. If you must cancel, please call prior to your appointment. (Appropriate phone numbers found on letter head above). To avoid a \$10.00 cancellation fee, please call 24 hours in advance, or, be sure to reschedule your appointment within the same week. If you are more than 15 minutes late for you appointment, it may be necessary to reschedule. If you do miss a physical therapy appointment without notice, your visit will be considered a “no show”. In this case, Elite Physical Therapy reserves the right to charge a \$20.00 no show fee. If you miss more than 2 physical therapy appointments, you may be discharged from physical therapy. If your visits are being filed under Worker’s Compensation or Short Term Disability, please be aware that your claim may be jeopardized if you miss appointments without justifiable cause.
- **Cell Phones:** Except in emergency situations, please keep cell phones off or on vibrate mode as your therapist will require your full attention.
- **Children:** For your child’s safety, please do not bring your children to physical therapy. We do realize that occasional situations may arise in which you must bring your children, but it should not be a common occurrence.
- **Insurance:** As a courtesy to you, we bill your insurance company for the services you receive at Elite Physical Therapy. However, any co-insurance and or co-pays are due at the time of service. We will also verify your benefits for our services however; this **is not**, a guarantee. We don’t accept third party billing. Please see receptionist regarding rules on auto claims.

If you have any questions or concerns regarding these policies and guidelines, please feel free to ask your physical therapist or the front desk staff. We are certain this will be a mutually rewarding experience and we look forward to assisting you in attaining your goals.

Sincerely,

The Staff of Elite Physical Therapy

I acknowledge I have read and understand the above information.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



Date: \_\_\_\_\_

First: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

Email Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ His/Her Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Date of injury / date of onset: \_\_\_\_\_ Is this the result of an accident? \_\_\_\_\_

If yes, what type of accident? AUTO / WORK / OTHER: \_\_\_\_\_

**Insurance Information:**

Primary Carrier: \_\_\_\_\_ Secondary Carrier: \_\_\_\_\_

Insured: \_\_\_\_\_ Insured: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

ID#: \_\_\_\_\_ ID#: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Assignment /Release/Consent:**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
And assign directly to Elite Physical Therapy, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Elite Physical Therapy, LLC may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**Consent:**

By signing this form I give Elite Physical Therapy consent to treat me/or my dependent(s)

\_\_\_\_\_  
Signature of Patient, Parent, Guardian

\_\_\_\_\_  
Date



## 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.

Federal Law (the Health Insurance Portability and Accountability Act (HIPAA)) requires that health care providers inform patients of their rights regarding how the provider 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. This Privacy Notice describes our privacy practices that relate to your protected health information. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

### **Your Health Record and Protected Health Information**

Each time you receive medical care from our practice, a record of your visit is created. This record typically includes, but is not limited to, information such as your name, age, address, a brief medical history, symptoms, any test results, the treatment provided to you, treatment plans devised for your care, and notes on follow-up care to be performed. How your health care information may be used and what control you may exercise over the use of your healthcare information is described in this Privacy Notice.

### **Uses and Disclosures of Protected Health Information**

Our Practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the practice has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

**Treatment:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment:** Your protected health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.



**Health Care Operation:** your health information may be used as necessary to support the day-to-day activities and management of Elite Physical Therapy, LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Other examples might include: employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

**Law enforcement:** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Other uses and disclosures for health care operations may include:**

**Appointment Reminders:** Your health information may be used to contact you, a family member or friend involved in your health care as authorized by you as a reminder that you have an appointment for treatment or medical care at our facility. We may also leave a message on your answering machine/voicemail system unless you tell us not to.

**Treatment Alternatives:** We may use or disclose your protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health Related Benefits and Services:** We may use or disclose your protected health information to tell you about health related benefits or services that may be of interest to you.

**Individuals Involved in Your Care or Payment of Your Care:** We may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone assisting you in the payment for your care. We may also tell your family or friends that you are in the facility at the time of your care. If you want any of this information restricted you must communicate that to us using the appropriate procedure.

**Worker's Compensation:** The facility may release your health information to comply with worker's compensation laws or similar programs.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly



relevant to the person's involvement with your care, we may disclose your protected health information as described.

**Uses and Disclosures which you authorize:** Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

## Individual Rights

Although your health record is the physical property of the healthcare practitioner or Facility that compiled it, the information belongs to you. You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Please contact our HIPAA Privacy Officer if you have questions about access to your medical record.

## Elite Physical Therapy, LLC Duties

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

## Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

## Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health



information be submitted in writing. You may obtain a form to request access to your records by contacting Margie Smith. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

## Complaints

We encourage you to express any concerns you may have regarding the privacy of your information. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Paul Hecker, MPT  
Elite Physical Therapy, LLC  
1011 Grove Road, Suite A-2  
Greenville, SC 29605  
(864) 233-5128

You also have the right to express complaints to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You will not be penalized or otherwise retaliated against for filing a complaint.

## Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

HIPAA Privacy Officer  
Paul Hecker, MPT  
Elite Physical Therapy, LLC  
1011 Grove Road, Suite A-2  
Greenville, SC 29605

## Effective Date

This Notice is effective on or after December 14, 2009.

Elite Physical Therapy, LLC  
1011 Grove Road, Suite A-2  
Greenville, SC 29605  
(864) 233-5128

Billing phone: (888) 456-4364



## Acknowledgement of Receipt Of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature	Date
Description of Personal Representative's Authority (attach necessary documentation)	

For Office Use Only

**We were unable to obtain a written acknowledgement of Receipt of the Notice of Privacy Practices because:**

- The individual refused to sign.
- Other: \_\_\_\_\_  
\_\_\_\_\_

Employee preparing document: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_



## Compound Authorization for Release of Information

This form is necessary to allow us to communicate with you and others that may be involved in your care. To fill it out, please fill in all blanks and checkboxes as appropriate, allowing us to speak with other professionals regarding your care. If you do not fill in blanks as specified – we cannot legally speak to anyone regarding your care, including family members etc.

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Elite Physical Therapy** is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

<b>Entity to Receive Information.</b> Check each person/entity that you approve to receive information.	<b>Description of information to be released.</b> Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail – Home # _____ <input type="checkbox"/> Voice Mail – Cell # _____ <input type="checkbox"/> Voice Mail – Work # _____	<input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial Information <input type="checkbox"/> Medical Information
<input type="checkbox"/> Other _____	<input type="checkbox"/> Appointment Information <input type="checkbox"/> Financial Information <input type="checkbox"/> Medical Information

The **purpose** of this authorization is to meet the patient's request for information disclosures and uses, and will be enforced until revoked by patient. This practice will verify the identity of any entity requesting protected health information using patient's date of birth.

### Rights of the Patient

- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of Patient or Personal Representative Date \_\_\_\_\_

Description of Personal Representative's Authority (attach necessary documentation)

\_\_\_\_\_

### Office use only:

Receiving Employee: \_\_\_\_\_

Date received: \_\_\_\_\_

Copy given to patient if requested