FYZICAL®
Therapy & Balance Centers

Information for Gold coast Insurance

Please read carefully and initial

(Fill Out in Black Ink)

Failed/Cancelled Appointments

Your body will be going through transitions while on your way to recovery. Please understand that your pain will probably increase and decrease as your treatment progresses. Either condition can seem to be a reason not to come in: A) you're feeling worse and think the treatment is not working or, B) you're feeling better and it's a great day for golfing. Neither of these conditions is legitimate reason not to come: A) if you're in pain, come in and get it helped, B) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc. **Our therapists can't help you *or* someone else if you fail to give proper notice and reschedule in the same week**. We are happy to reschedule your visit in the same week. You may need to see a therapist other than the one who normally treats you if you do rearrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands.

As is standard in the medical profession, we request that you provide us with a twenty-four (24) hour cancellation notice. If you fail to show for a scheduled appointment or cancel without twenty-four hours notice, you will be charged $35.00. This is not covered by your insurance, and will be your responsibility. We would like to request your help in working with us, and communicating with us so that we can provide your care and care to the other patients. We are happy to reschedule your visit with in the week so that we can continue your progress towards your goals.

I understand that a specific time slot is reserved for me when I schedule an appointment, and I accept full responsibility for my scheduled appointments. I understand that FYZICAL Therapy & Balance Centers (FYZICAL) does offer a one time exception for legitimate reasons. (Ex. illness, or emergency) _____ Initial

I understand that the $35.00 late cancellation or no-show charge is not covered by Gold Coast and that I will be personally responsible for any late cancellation or no-show fees. _____ Initial

I understand that it is FYZICAL Therapy & Balance Centers's policy to discharge any patient that has three late cancellations and/or no shows. _____ Initial

Authorization for Treatment

All procedures will be thoroughly explained to you before they are performed.

There are certain inherent risks with physical therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. There is, also, a small risk or possibility that you could experience a new injury. It is important to listen to the advice and exercise techniques that you will be instructed in. You will be able to control any procedure by stopping if you feel an increase in pain or discomfort.

The physical therapist or physical therapist assistant will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced perform any procedure that you do not wish to perform.

Based on the above information I agree to cooperate fully and to participate in all physical therapy procedures and to complying with the plan of care as it is established.

NOTICE TO PATIENTS: for personal safety or for safety of those who accompany you to your visits, do not use or let them use any equipment without a staff member present.

Supplies/Referrals

_____ Initial

Sometimes during the course of treatment supplies for home use, such as foam rollers or fitness balls, will be suggested or we will refer another company to you to purchase supplies or equipment. We can provide these supplies for purchase. You are welcome to purchase these outside of the office. You are not obligated to purchase supplies from FYZICAL Therapy & Balance Centers, or required to only purchase from vendors we refer you too

_____ Initial

Cash Accounts

If you do not wish our office to bill your insurance company for services rendered or do not have an insurance carrier, please let us know at this first visit. Cash payments for services are due at the time of service and are not invoiced.

Initial

Litigated or Non Litigated Personal Injury Cases

We do not accept liens for payment under any circumstances. If you are involved in a third party personal injury-case such as a motor vehicle accident or slip and fall, is your responsibility to collect from the third party if they do not allow for direct billing. You will be required to provide your private insurance or pay cash. In most instances, the third party will not pay the provider, but instead requires that only the injured party can make the claim and receive the funds. It is also typical for private insurances to not cover and recoup money from FYZICAL and, therefore, we will provide you with paper work to submit to your insurance company for reimbursement.

Initial

Notice of Information Practices

Have read and fully understand FYZICAL Therapy & Balance Centers's notice of information practices. I understand that FYZICAL Therapy & Balance Centers may use or disclose my personal health information for the purposes of carrying out treatment, obtaining a 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 notified the practice. I also understand that FYZICAL Therapy & Balance Centers will consider the request for restrictions on a case-by-case basis, but does not have to agree to request for restrictions.

I authorize the use and disclosure of my personal health information for purposes as noted in Advantage Physical Therapy's notice for information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initial

Designated individuals authorization

I authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related billing and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name _____ Relationship _____

Name _____ Relationship _____

Payment for your care

We appreciate the opportunity to provide your needed care. Physical Therapy is typically paid for by medical insurance, but there can be many exceptions to this. Coverages that may be excluded from benefit payment can not be always anticipated. All insurance policies are different and benefits can change from year to year. The following is information to help explain payment options and responsibilities.

Patients are ultimately responsible for the payment of services received. We understand that most medical events are unplanned and we will work with you in every way possible to help you facilitate payment.

Our purpose is to provide you with 100% excellent care so that you feel fully rehabilitated and can return to your normal, daily activities and know how to take care of yourself. If you have any concerns about your ability to meet your financial responsibilities, please let us know so that we can work together and come up with a plan to return you to your activities with less pain and greater ability.

Insurance policy / assignment of benefits

Initial

I request that payment of insurance benefits be made to FYZICAL on my behalf for any services given to me. As a courtesy to you, we will submit to your services to your insurance carrier, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third-party, be involved in prolonged insurance negotiations; this is your responsibility. If you prefer to submit your bill to your insurance company, please refer to our Cash pay policies.

Initial

Have read and fully understood all the above information and hereby agreed to comply as outlined above.

_____ _____

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to FYZICAL Therapy & Balance Centers and its entities. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by FYZICAL Therapy & Balance Centers. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Office Manager, FYZICAL Therapy & Balance Centers, 4572 Telephone Rd. Ste 903 Ventura, CA 93003.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke the authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosure for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and other professionals involved in your care will use information in your medical record and information you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Options: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved in Your Care: With your written agreement, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may

make your requests by sending your name and address to the Office Manager, FYZICAL Therapy & Balance Centers, 4572 Telephone Rd. Ste 903 Ventura, CA 93003.

Other Uses and Disclosures:
We are permitted and/or required by law to make certain other uses and disclosures or your personal health information without your consent for the following:

- Any purpose required by law
- Public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence
- To the Food and Drug Administration to report adverse events, product defects, or to participate in recalls
- To your employer when we have provided healthcare to you at the request of your employer
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings
- Court or administrative ordered subpoena or discovery request
- To law enforcement officials as required by law to report wounds and injuries and crime
- If you are a member of the military, we may also release your personal health information for national security or intelligence activities
- To workers' compensation agencies for workers' compensation benefit determination

RIGHTS THAT YOU MAY HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

Access to Your Personal Health Information
You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the Office Manager. If you request copies, you may be charged a nominal fee for copying and postage.

Amendments to Your Personal Health information
You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments, but will give each request careful consideration. All amendment requests, must be in writing, sign by you or your legal representative, and must state the reasons for the amendment/ correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the Office Manager.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or healthcare operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed- to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such notice to the Office Manager.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing to the Office Manager, FYZICAL Therapy & Balance Centers, 4572 Telephone Rd. Ste 903 Ventura , Ca 93003. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding the Notice, you may contact the Office Manager, FYZICAL Therapy & Balance Centers, 4572 Telephone Rd. Ste 903 Ventura, CA 93003.

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Client or Legal Representative's Signature **Date**

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Print Name