

## **NOTICE OF PATIENT INFORMATION PRACTICES**

**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.**

### **ALL COUNTY PHYSICAL THERAPY'S LEGAL DUTY**

**All County Physical Therapy** 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 that are described herein.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

**All County Physical Therapy** uses your personal health information primarily for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, **All County Physical Therapy** may 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.

**All County Physical Therapy** 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 to do so by law.

In any other situation, **All County Physical Therapy** may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

### **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons 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. **All County Physical Therapy** will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

### **CONCERNS AND COMPLAINTS**

If you are concerned that **All County 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 practice manager at the address below. You may also send a written complaint to the US Department of Health and Human Services. For further information on **All County Physical Therapy's** health information practices or if you have a complaint, please contact them following person:

**All County Physical Therapy, P.C.  
73 North Ocean Avenue, Suite 1  
Patchogue, New York 11772  
Phone: 631-475-0700 Fax: 631-475-0719**

# All County Physical Therapy, P.C.

## CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I HEREBY CONSENT TO THE EVALUATION AND TREATMENT OF MY CONDITION BY A LICENSED PHYSICAL THERAPIST EMPLOYED BY ALL COUNTY PHYSICAL THERAPY, P.C.

I UNDERSTAND THAT I WILL BE RECEIVING AN INITIAL EVALUATION FOLLOWED BY ONE OR SEVERAL TREATMENT SESSIONS. THESE SESSIONS MAY INCLUDE ONE OR MORE OF THE FOLLOWING: **JOINT MOBILIZATION, SOFT TISSUE WORK, MANUAL THERAPY, ELECTRICAL STIMULATION, ULTRASOUND, HEAT/ICE, TRACTION, PASSIVE/ACTIVE RANGE OF MOTION, STRENGTHENING, STRETCHING, EXERCISE, AND/OR ACTIVITY OF DAILY LIVING MODIFICATION.**

I UNDERSTAND THAT THERAPY CAN BE BENEFICIAL, BUT SOME RISKS AND DISCOMFORTS MAY ARISE. I ALSO UNDERSTAND THE RISKS AND CONSEQUENCES OF NO TREATMENT. I UNDERSTAND THAT I CAN DISCONTINUE TREATMENT AT ANYTIME. I CONFIRM THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM.

### BENEFIT VERIFICATION

I UNDERSTAND IT IS MY RESPONSIBILITY TO VERIFY MY INSURANCE BENEFITS. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY CHARGES INCURRED.

### ASSIGNMENT OF BENEFITS AND INSURANCE PROCEEDS

I HEREBY AUTHORIZE PAYMENT FROM MY INSURANCE COMPANY OF MEDICAL BENEFITS FOR SERVICES RENDERED TO ALL COUNTY PHYSICAL THERAPY, P.C. BY AN ASSIGNMENT OF BENEFITS. THE COMPLETION OF INSURANCE FORMS AND THE ASSIGNMENT OF INSURANCE BENEFITS DO NOT RELIEVE THE UNDERSIGNED OF THE OBLIGATION TO PAY THE AMOUNT OWED FOR PHYSICAL THERAPY.

### RELEASE OF INFORMATION

I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO FILE CLAIMS WITH MY INSURANCE COMPANY AND INFORMATION TO MY PHYSICIAN/S. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

### CANCELLATION POLICY

IN ORDER TO MAINTAIN ALL COUNTY PHYSICAL THERAPY'S HIGH STANDARD OF CARE, WE ASK THAT YOU GIVE US 24-HOUR NOTICE IF CANCELING AN APPOINTMENT. THIS ALLOWS US AMPLE TIME TO SCHEDULE AND PROVIDE CARE TO ANOTHER PATIENT. I UNDERSTAND THAT IF I CANCEL ON THE SAME DAY OF SERVICE OR I DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT, I WILL BE CHARGED \$25, FOR WHICH I AM PERSONALLY RESPONSIBLE.

### FINANCE CHARGES

**On balances of 30 days or over, we will assess a FINANCE CHARGE of 1.5% per month. Patient is personally responsible for any collection agency fees incurred.**

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL THE ABOVE AND AUTHORIZE TREATMENT BY ALL COUNTY PHYSICAL THERAPY, P.C.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

# ALL COUNTY PHYSICAL THERAPY, P. C.

## Registration Form / Workers' Compensation

(Please Print)

TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Information			
NAME (Last, First Middle)	BIRTHDATE	SSN#	Sex
LOCAL ADDRESS		CITY, STATE, ZIP CODE	
PRIMARY PHONE	SECONDARY PHONE	EMAIL ADDRESS	
Case Information			
REFERRING PHYSICIAN		PRIMARY CARE PROVIDER	STATUS
CONDITION RELATED TO <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER _____		<input type="checkbox"/> MARRIED	
		<input type="checkbox"/> SINGLE	
DATES UNABLE TO WORK (MM/DD/YY) /   /   -   /   /		DATES OF HOSPITALIZATION (MM/DD/YY) /   /   -   /   /	<input type="checkbox"/> FULL TIME STUDENT
		<input type="checkbox"/> PART TIME STUDENT	
		<input type="checkbox"/> EMPLOYED	
		<input type="checkbox"/> OTHER	
Workers' Compensation Information			
WCB CASE NUMBER		CARRIER CASE NUMBER (IF KNOWN)	DATE / TIME OF INJURY
ADDRESS WHERE INJURY OCCURRED (CITY, TOWN OR VILLAGE)		CITY, STATE, ZIP CODE	
EMPLOYER'S NAME		EMPLOYER'S ADDRESS AND PHONE	
INSURANCE CARRIER		INSURANCE CARRIER'S ADDRESS / PHONE	

CASE MANAGER:

HOW DID INJURY OCCUR?

BODY PART?

CURRENTLY WORKING? \_\_\_\_\_ YES    \_\_\_\_\_ NO    FULL DUTY \_\_\_\_\_    LIGHT DUTY \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize [YOUR FACILITY NAME HERE] or insurance company to release any information required to process my claims.

X \_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE
DATE

