

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.
PATIENT INFORMATION CONSENT FORM

I have read and fully understand All County Physical Therapy's Notice of Information practices. I understand that All County Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluation of the quality of services provided and any administrative operation 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 All County Physical Therapy will consider requests for restriction 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 All County Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Patient Signature

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 _____		DATES UNABLE TO WORK (MM/DD/YY) / / - / /	<input type="checkbox"/> MARRIED
			<input type="checkbox"/> SINGLE
DATES OF HOSPITALIZATION (MM/DD/YY) / / - / /		DATES UNABLE TO WORK (MM/DD/YY) / / - / /	<input type="checkbox"/> FULL TIME STUDENT
			<input type="checkbox"/> PART TIME STUDENT
DATES UNABLE TO WORK (MM/DD/YY) / / - / /		DATES OF HOSPITALIZATION (MM/DD/YY) / / - / /	<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

