

Healy Physical Therapy & Sports Medicine, Inc.

General Information

Thank you for choosing Healy Physical Therapy & Sports Medicine, Inc. for your physical therapy. It is our goal to provide you with a high quality rehabilitation treatment plan individualized to meet your specific needs. So that we have a mutual understanding concerning your treatment, we ask that you review the following information prior to starting your program.

Appointments: Typically, appointments will be scheduled with your therapist 1 to 3 times per week. We ask that you make every effort to keep appointments and to arrive by your scheduled time. If you arrive more than fifteen minutes late for an appointment we cannot guarantee that you will be seen that day. Please help us to serve you (and all of our patients) better by keeping scheduled appointments.

Workers' Compensation Patients: In consideration of other patients, we need to firmly adhere to our 24 hour cancellation policy. If you miss or cancel any appointments, we will notify your referring physician, WC insurance company and nurse case manager in writing of missed appointments. If you miss and/or cancel at least 3 appointments at our discretion, we may put your physical therapy treatment on HOLD until you follow up with your referring physician and obtain a new written physical therapy treatment order to resume with your treatment.

Clothing: Please wear loose and comfortable clothing for each session, we have changing rooms for your convenience.

Fees:

\$25 nonsufficient funds check fee

Payment: You are responsible for all payment of services rendered by Healy Physical Therapy & Sports Med., Inc. whether your insurance company pays or not. Although we will do our utmost to assist in gathering information regarding claims payment, it is your responsibility to know your benefit and coverage limits as well as which services require authorization. Please note your insurance contract is between you and the insurance company; we are not a party to that contract. Our relationship is with you and not your insurance company. Payment due at the time of service for copays, deductibles, services deemed noncovered by your insurer and any other items addressed herein. Budget payments are available on an individual consideration basis. We accept cash, check, credit cards and money orders.

Rules for Plans of Nonparticipation: We will provide the service of submitting claims to your insurer if we are nonparticipating; however, if payment is not received within 90 days from the date of service, the bill then becomes your financial responsibility. You are responsible for our entire charge less any payment from your insurer. If we do not participate with your secondary (or any nonprimary) insurer, you are responsible for that portion of your bill at the time of service.

If at any time you have any questions about your treatment program, please bring your concerns to the attention of your therapist. Also, our office staff is available to answer any questions regarding insurance, scheduling and to assist you in anyway that will make your participation in your program here more convenient and worthwhile.

IN SIGNING THIS POLICY...

You assign your insurance benefits directly to Healy Physical Therapy & Sports Medicine, Inc. (Healy PT), you authorize Healy PT to release any medical information necessary for clinical or claims payment purposes, you certify all information given is correct to the best of your knowledge, you agree to release all treatment records upon request. If you do not wish to release your medical records for any reason, please indicate below. Your signature on this document serves as a "signature on file" for all claims submitted to your insurance company for services rendered.

I request the following restriction to the use or disclosure of my health information

The practice will not disclose patient information (This includes discussions for treatment, Rx renewals, details of appointments and billing problems among other information) to anyone other than the people listed on the lines below. You must specify each person including non-custodial parents, spouses, guardians and other family members.

IF NO NAMES ARE GIVEN, NO PATIENT INFORMATION WILL BE DISCUSSED WITH ANYONE OTHER THAN THE PATIENT.

Names: _____

Circle one:

Yes No The practice has my permission to call my home number to confirm appointments and may leave a message on my answering machine or with the person answering the phone.
Yes No the practice may contact me at work to reschedule appointments or confirm existing appointments.

Again, thank you for choosing Healy Physical Therapy & Sports Medicine, Inc., we look forward to working together toward achieving your rehabilitation treatment goals.

Patient signature _____

Date _____

Personal Representative or Guardian Signature _____

Date _____

**Healy Physical Therapy & Sports Medicine, Inc.
Consent for Specific Treatments**

In physical therapy, a therapist may need to work on certain muscles in sensitive areas such as the groin chest and buttock areas depending upon the diagnosis you are being treated for. During your treatment session a therapist will always ask permission to treat these areas as well as to explain the rational for the treatment. As a patient you have the right to refuse any treatment that may make you feel uncomfortable if this was to occur please let your therapist know and he or she will stop treatment immediately. If you have any questions or concerns regarding your treatment you may contact Kevin Muldowney, PT our Clinical Manager and he will address and concerns you may have. Healy Physical Therapy & Sports Medicine, Inc. appreciates your business and wants your time with us to be a therapeutic and professional experience.

Patients Name: _____

Date: _____

Patients Signature: _____

**Notice of Privacy Practices
And
Patient Acknowledgment Form**

Healy Physical Therapy & Sports Medicine, Inc. is required by a federal law known as "The Health Insurance Portability and Accountability Act" (HIP AA) as well as by Rhode Island state law to maintain the privacy of your medical and health information; also referred to as "Protected Health Information" (PHI).

Our notice of Privacy Rights and Practices describes how information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully. When we use or disclose your Protected Health Information, we are required to abide by the terms of the notice (or any other Notice in effect at the time of the use of the disclosure).

You have the right to request in writing that we restrict how Protected Health Information about you is used or disclosed. We are not required to agree with this restriction, but if we do, you will receive written confirmation of our agreement to which we will be bound.

Your signature below constitutes your acknowledgement that you have received a copy of our Notice of Privacy Rights and Practices, and your consent under federal and state laws to the kinds of uses and disclosures of Protected Health Information mentioned in our Notice.

Patient Signature

Date

Personal Representative or Guardian Signature

Date

Relationship to Patient

Authorization for Patient Release of Information

I the undersigned, hereby authorize Healy Physical Therapy & Sports Medicine, Inc. and my attending physician to release my Protected Health Information (PHI). I have received and reviewed a copy of the Healy Physical Therapy & Sports Medicine, Inc. Notice of Privacy Rights and Practices and I understand that Healy Physical Therapy & Sports Medicine, Inc. will only disclose the minimum information necessary for my treatment and payment of my services according to the Health Insurance Portability and Accountability Act (HIPAA/US. Department of Justice 5 U.S. C 552a (b) regulating protected health information (PHI).

I understand that I have the right to limit the kind of information released. I further understand that I have the right to revoke this consent at any time by written request to my provider.

Patient Signature

Date

Personal Representative or Guardian Signature

Date

Relationship to Patient