Dear Patient,

Thank you for choosing CPT for your physical and occupational therapy needs! As a health care service provider, we realize that you DO have a choice for your care – and we are honored that you have chosen us!

To prepare for your first visit and initial examination, we would like to provide you with some information and helpful hints. The healthcare system can be challenging to navigate – and we hope that this helps to take some of the guesswork out of the process.

What should I wear to my appointments?
We recommend you wear comfortable clothing. If we will be addressing issues with a particular body part such as your knee or shoulder, it would be helpful to wear clothing that allows "easy access" to that region. Part of your examination may include "palpation" or touching of the injured area.

Can I have someone accompany me for the initial examination?
We understand that medical appointments can sometimes be overwhelming and having a friend or family member who knows you well can be helpful. We will do our best to accommodate any such request. With COVID-19, we reserve the right to restrict non-patient visitors from the treatment areas if we determine social distancing cannot be maintained.

Can I have someone accompany me for my treatment sessions?
During COVID-19, we are respectfully asking all non-patient visitors to wait in their vehicles. This is for the protection of all patients and our staff. Under pre-approved circumstances, a non-patient visitor may accompany a patient. In doing so, the safety and privacy of other patients cannot be compromised.

Will my insurance cover the cost of my therapy?
There are many insurances and even more insurance policies out there with different levels of coverage. Our front desk administrator will ask for your insurance card(s). Your insurance card will be copied, and we will call your insurance company on your behalf to verify your benefit eligibility and any out of pocket costs to you. It is important that you present ALL insurance information on the first day.

What if I cannot afford the out-of-pocket costs associated with my insurance plan?
Providing you the care that you need so that you can get back to doing what you want to is important to us! CPT is always willing to assist our patients with the financial burden associated with co-payments, deductibles, and co-insurance costs. If cost of care is a concern, please do not hesitate to mention it to

our front desk administrator or your therapist. All staff are familiar with our policies to help with these circumstances and will initiate the necessary process.

Do I need to complete paperwork?

Yes. Most of the necessary paperwork is attached here. It is important that you complete ALL of it to the best of your ability. If there is something you do not understand, simply leave it blank and we can review it with you during your first visit. If you maintain a separate copy of your medical history and/or medication list, you may present them with this paperwork (in place of writing it out) and we can make a copy for your patient chart.

Should I bring any test results to my appointment?

Very often, patients have undergone tests that are pertinent to their reason for a referral to physical or occupational therapy. These may include tests such as X-ray, EMG, MRI, CT scan, or bloodwork. If you have had testing relevant to your diagnosis, please bring a copy of your test results to your first appointment OR notify your therapist about the testing and where it was performed – we can request a copy of the results from the service provider.

How often will I have appointments?

Your therapist will complete an initial examination on your first visit. At the end of that visit, the therapist will discuss with you their findings and thoughts about appropriate interventions, which includes the frequency and duration of your treatment. Typically, patients are seen 2-3x/week for a period of 4 – 6 weeks. This varies based upon your diagnosis and complexity of your problem(s).

How long are the appointments?

Initial visits are usually a full hour. After that, visits typically last 45 – 75 minutes, depending upon the condition we are seeing you for and how much time your therapist determines is needed to provide the best care for you. No two patients are the same!

Is there anything else I need to know?

We are excited to have you come in to see us! We do our best to create a fun atmosphere that helps you heal and feel supported while doing so. Please know that we are here for YOU! Never hesitate to reach out to any of our staff members with an issue or concern!

We are looking forward to meeting you and getting you started on the road to recovery!

Sincerely,

The CPT Team

Patient Information

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☐ New Patient ☐ Returning Patient Email: _____

Patient Name: _____

Address: _____
STREET # OR P.O. BOX CITY STATE ZIP CODE

Date of Birth: _____ Age: _____ ☐ MALE ☐ FEMALE SS#: _____

Home Phone: _____ Work or Cell Phone: _____

Patient Status: ☐ Single ☐ Married ☐ Widowed ☐ Other

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES FOR ANY REASON?	☐ **YES** ☐ **NO**
IS THIS INJURY THE RESULT OF A WORK RELATED ACCIDENT?	☐ **YES** ☐ **NO**
IS THIS INJURY THE RESULT OF AN AUTO RELATED ACCIDENT?	☐ **YES** ☐ **NO**

HOW DID YOU HEAR ABOUT US?

☐ **Newspaper** ☐ **Past Patient / Friend** ☐ **Medical Doctor** ☐ **Website** ☐ **Yellow Pages**

☐ **Other:** _____

DOCTOR / EMERGENCY CONTACT INFORMATION (required)

Referring Physician: _____ Primary Care Physician: _____

Date Last Seen: _____ Date Last Seen: _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

PRIVATE INSURANCE / FINANCIAL RESPONSIBILITY INFORMATION (required)

Person Financially Responsible: _____ Phone: _____

Address: _____

Relationship to Patient: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Is the Patient the Subscriber: ☐ **YES** ☐ **NO** **Is the Patient the Subscriber:** ☐ **YES** ☐ **NO**

RECENT SYMPTOMS

Have you had unusual fatigue lasting 2-4 weeks or longer?	☐ **YES** ☐ **NO**
Have you recently had any unexplained weight change - loss OR gain?	☐ **YES** ☐ **NO**
Have you recently had a fever lasting more than 2 weeks?	☐ **YES** ☐ **NO**
Have you recently had nausea or vomiting?	☐ **YES** ☐ **NO**
Have you noticed any change in your bowel or bladder habits?	☐ **YES** ☐ **NO**
Have you been experiencing pain that occurs or worsens at night?	☐ **YES** ☐ **NO**

Patient Information

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MEDICAL HISTORY | Please check any medical conditions that we should be aware of:			
	Alzheimer's		Blood Disorder / Blood Clot
	Cardiovascular Disease		Concussion / Head Injury
	Cauda Equina Syndrome		Dizziness / Vertigo
	Current Infection		Epilepsy / Seizures
	Diabetes: Type 1 or Type 2		Hepatitis C / Infectious Disease
	Fibromyalgia		Heart Disease/Heart Attack
	Fracture or Suspected Fracture		Joint Replacement
	High Blood Pressure		Lung Disorder (Asthma/Bronchitis/Emphysema)
	History of Cancer		Metal Implants or Pins
	Huntington's		Pacemaker
	Immunosuppression		Scoliosis / Back Disorder
	Lupus		Ulcer / Digestive Disorder
	Muscular Dystrophy		Tuberculosis
	Obesity	**For Women Only**	
	Osteoarthritis		Pelvic Inflammatory Disease
	Parkinson's		Complicated Pregnancies/Deliveries
	Rheumatoid Arthritis		Endometriosis
	Traumatic Brain Injury		Are you pregnant? Yes No
Have you received medical or rehabilitative care for this injury ? Please check all that apply.			
	Chiropractor		Physical Therapy
	Orthopedist		Occupational Therapy
	Neurologist		CT Scan
	Podiatrist		EMG or Nerve Test
	General Practitioner		MRI
	Massage Therapist		X-Ray
	Pain Management		Joint or Spine Injections

Were you hospitalized at any time for **this injury?:** ☐ **YES** ☐ **NO**

If yes please list hospital and date: _____

Please list surgical history by type and date below:

Type: _____ Date: _____ / _____ / _____

Type: _____ Date: _____ / _____ / _____

Type: _____ Date: _____ / _____ / _____

Type: _____ Date: _____ / _____ / _____

(Continued on next page)

Patient Information

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MEDICATIONS LIST | Please fill out completely or provide us with a list of your medications that we can copy:

NAME	DOSAGE & QUANTITY	NAME	DOSAGE & QUANTITY
PRESCRIPTION		**HERBAL**	
		VITAMIN/MINERAL/DIETARY SUPPLEMENTS	
OVER THE COUNTER			
		OTHER	

Allergy History: (medications, food, latex, etc...)_____

ILLNESS OR ONSET OF PAIN INFORMATION (required)

☐ ILLNESS ☐ INJURY What body part is involved: _____ ☐ LEFT ☐ RIGHT ☐ BOTH

Onset of Symptoms: _____

Injury Occurred: ☐ Home ☐ Employment ☐ School ☐ Recreation ☐ Pedestrian ☐ MV A/Auto ☐ Other : _____

** If insurance company is involved as a result of an accident next section must be filled out*

WORKERS COMP / LIABILITY / AUTO CLAIM - PLEASE COMPLETE SECTION BELOW

Date of Injury Was: _____ /_____ /_____

State that incident occured in: _____ Claim Number: _____

Name of Insurance: _____ Adjuster/Contact Name: _____

Phone Number: _____ Extension Number: _____

Has an Attorney Been Obtained: ☐ **YES** ☐ **NO** - if ***YES:*** Attorney Name: _____Phone: _____

EMPLOYMENT INFORMATION (required)

Employer: _____ Phone: _____ ☐ Retired

Address: _____ Job Description: _____

Are you a student? ☐ **YES** ☐ **NO** // ☐ **FULL TIME** ☐ **PART TIME**

To the best of my knowledge, the information that I have given is complete and true.

Patient/Guardian Signature:_____ **Date:** _____ / _____ /_____

Therapist Signature: _____ **Date:** _____ / _____ /_____

MFES INITIAL VISIT

Patient Name:_____ Date:_____

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Please rate your pain level with activity (Circle One):
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Very Severe Pain)

Instructions: On a scale of 0 to 10, how confident are your that you can do each of these activities without falling, with a 0 meaning "not confident/not sure at all", 5 being "fairly confident/fairly sure", and 10 being "completely confident/completely sure".

- If you have stopped doing the activity at least partly because of being afraid of falling, score 0
- If you have stopped the activity purely because of a physical problem, leave that item blank
- If you would not currently do the activity for other reasons, please rate that item based on how you think would score if you had to do the activity today.

	Activity	Not Confident					Fairly Confident				Completely Confident
1	Get dressed and undressed	0	1	2	3	4	5	6	7	8	9	10
2	Prepare a simple meal	0	1	2	3	4	5	6	7	8	9	10
3	Take a bath or shower	0	1	2	3	4	5	6	7	8	9	10
4	Get in/out of a chair	0	1	2	3	4	5	6	7	8	9	10
5	Get in/out of bed	0	1	2	3	4	5	6	7	8	9	10
6	Answer the door or telephone	0	1	2	3	4	5	6	7	8	9	10
7	Walk around inside your house	0	1	2	3	4	5	6	7	8	9	10
8	Reach into cabinets or closets	0	1	2	3	4	5	6	7	8	9	10
9	Light housekeeping	0	1	2	3	4	5	6	7	8	9	10
10	Simple shopping	0	1	2	3	4	5	6	7	8	9	10
11	Using public transportation	0	1	2	3	4	5	6	7	8	9	10
12	Crossing roads	0	1	2	3	4	5	6	7	8	9	10
13	Light gardening or hanging wash on clothesline*	0	1	2	3	4	5	6	7	8	9	10
14	Using front or rear steps at home	0	1	2	3	4	5	6	7	8	9	10

*Rate most commonly performed of these activities

Adult Depression Scale

Patient Name:_____ Date:_____

Instructions
Please circle the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? Yes **No**
2. Have you dropped many of your activities and interests? **Yes** No
3. Do you feel that your life is empty? **Yes** No
4. Do you often get bored? **Yes** No
5. Are you in good spirits most of the time? Yes **No**
6. Are you afraid that something bad is going to happen to you? **Yes** No
7. Do you feel happy most of the time? Yes **No**
8. Do you often feel helpless? **Yes** No
9. Do you prefer to stay home rather than going out and doing new things? **Yes** No
10. Do you feel you have more problems with memory than most? **Yes** No
11. Do you think it is wonderful to be alive now? Yes **No**
12. 12. Do you feel pretty worthless the way you are now? **Yes** No
13. Do you feel full of energy? Yes **No**
14. Do you feel that your situation is hopeless? **Yes** No
15. Do you think most people are better off than you are? **Yes** No

Score Meaning:
Answers in bold indicate depression. Score 1 point for each answer in bold.
A score >5 points is suggestive of depression
A score >/= 10 points is almost always indicative of depression
A score >5 points should warrant a follow-up comprehensive assessment

Pain Survey

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Name: _____ Date: _____

How would you describe your pain today?

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Pain Possible**

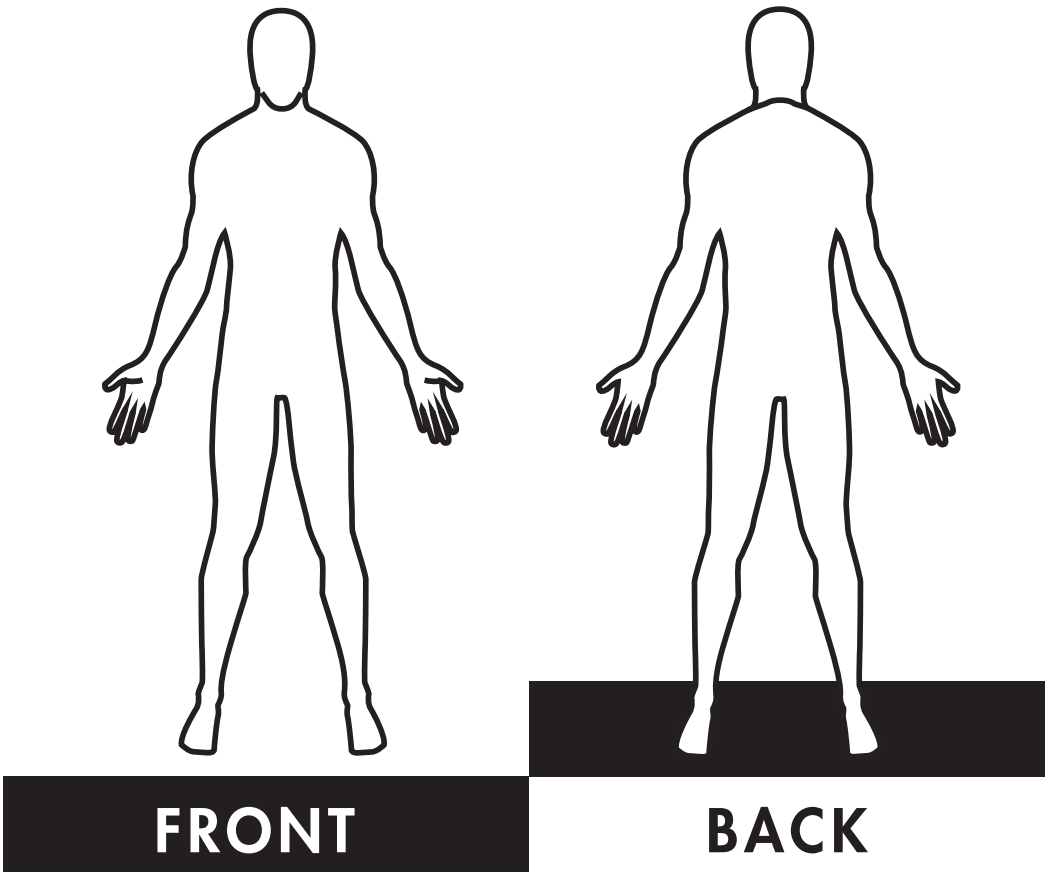
Using the 0 to 10 pain scale, please rate your ***least pain*** in the past 24 hours: _____

Using the 0 to 10 pain scale, please rate your ***worst pain*** in the past 24 hours: _____

Are your symptoms - ***worse*** - ***staying the same*** - ***better*** - since the onset of symptoms?

Using the key provided please mark on the outlines below where you are experiencing any of the following symptoms:

A -Achiness **N** - Numbness **T** - Tingling **S**- Stiffness **H** - Throbbing Pain
P - General Painful Feeling



General Information

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Thank you for choosing Comprehensive Physical Therapy (CPT) for your physical and/or occupational therapy needs. We are happy to assist you with your recovery. Physical and Occupational services require your consistent attendance in order to meet the goals expected by your referring doctor, your therapist and most importantly, YOU. We will do our best to schedule your therapy appointments at times that are most convenient for you. Please discuss your scheduling limitations with your therapist during your evaluation. CPT will provide you with a printed schedule of your weekly appointments.

Please read the statements below and initial them to indicate your understanding.

_____ I understand that I am required to arrive on time for my schedule appointments.

_____ I understand that if I can not make it to my scheduled therapy appointment **I am required to contact CPT by phone at 570-785-2018 (Forest City), 570-226.7303 (Hawley), 570-342-5333 (Dunmore), 570-282-3302 (Carbondale) to reschedule my appointment for another day within the same week.**

_____ I understand that if I do **not show up for or if I cancel a total of 3 visits over a two week time period that I will be discharged from therapy.**

_____ I understand CPT **may contact me via telephone and leave a detailed message.**

Appointments can be scheduled during our open hours:

Monday	First appointment is 8:00 am	Last appointment is 6:00 pm
Tuesday	First appointment is 8:00 am	Last appointment is 12:00 pm*
Wednesday	First appointment is 8:00 am	Last appointment is 6:00 pm
Thursday	First appointment is 8:00 am	Last appointment is 6:00 pm
Friday	First appointment is 8:00 am	Last appointment is 12:00 pm*

***Occupational Therapy hours may differ**

We do not schedule visits on Mondays, Wednesdays and Thursdays between 1:00 pm and 2:00 pm as this is the daily lunch break.

Patient/Guardian Signature:_____ **Date:** _____

Authorization & Guarantee

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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION
I hereby authorize the release of any information, including reports of diagnosis, treatment prognosis, treatment recommendation, benefits payable, as well as any other data pertinent to my treatment to the physician who referred me for therapy, as well as any organization responsible for payment of my account. I also authorize my referring physician to release to Comprehensive Physical Therapy, Inc . any and all medical or other information pertinent to my treatment.

MEDICARE
I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I ok any holder of medical or other information about me, to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance.

GUARANTEE OF PAYMENT
In consideration of services rendered to me by ,Comprehensive Physical Therapy, Inc. I hereby guarantee payment for ,any and all services rendered to which are not covered or allowable by insurance, together with collection costs, including reasonable attorney's fees. I also understand that all bills are due and payable upon presentation and further agree to pay interest or a monthly service charge on all such amounts not paid when due at the rate of 1.5% per month (18% APR).

RETURNED CHECKS
We are happy to accept your personal check, however, there will be a $25.00 fee for any check returned for non-payment to Comprehensive Physical Therapy, Inc.

SUPPLIES
All Supplies are not returnable and are non-refundable.

PRIVATE INSURANCE
I understand that as a courtesy, Comprehensive Physical Therapy, Inc. will bill my/insurers private insurance once only for treatment/visits rendered. Should there be any changes in my insurance coverage during the course of physical therapy, I will provide Comprehensive Physical Therapy, Inc . with the new information . Failure of notification can result in possible denial of claim. In the event that payment is not received in 60 days , for any reason, you will be responsible for the full balance and will then need to deal with your carrier directly.

INSURANCE PRE-AUTHORIZATION
As a courtesy we will make every effort to contact your insurance carrier and attempt to make a determination as to your insurance coverage. However, any such determination of coverage is no guarantee of actual coverage or insurance payment for services rendered. We encourage you to contact your insurance company for any benefit information.

SUPERVISION OF CHILDREN
I understand that this facility is not an appropriate setting for children due to safety reasons for the child(ren), myself and other patients. Any child(ren) allowed in the treatment area may NOT play on the equipment or move around the treatment area without supervision. If the child(ren) becomes a problem due to safety concerns or distracts other patients, you will be asked to leave and reschedule when you have appropriate childcare arranged. Front desk staff and CPT employees are not responsible for supervision of children.

ASSIGNMENT OF BENEFITS
I authorize that the payment of authorized benefits be made directly to Comprehensive Physical Therapy, Inc. for any services that are reimbursable by Medicare, Medicaid, or any other third party sources.

CONSENT FOR TREATMENT
I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or available while a patient at Comprehensive Physical Therapy, Inc.

Signature of Patient / Insured

Patient's Agent / Representative

Witness By

Date

Payment Policy

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CO-PAY /CO-INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the named insurance on the patient registration form and assign directly to Comprehensive Physical Therapy (CPT) all insurance benefits, if any, otherwise payable to me for services rendered.

Co-payments are due at the beginning of each session and not considered billable. This is a contractual agreement between you and your insurance company. This includes Geisinger, Blue Cross/Blue Shield and many other private insurance plans.

If your contract carries a **co-insurance responsibility, a $15.00 payment will be collected at each visit**. This amount may not cover the total amount due for each visit; this amount is taken to offset the final balance and will be credited toward your total responsibility. Once CPT receives notice (EOB) and payment from your insurance carrier for all claims submitted and processed, you will either receive a bill from CPT for any additional unpaid balance, or a reimbursement check for any overpayment.

If your insurance carrier refuses to pay for services rendered, your deductible has not been met, or you classify as a self pay you will be required to pay Comprehensive Physical Therapy all applicable costs for services rendered. In the event of non-payment, your account will be assigned to collections.

OUTSTANDING DEDUCTIBLE

If your insurance policy has an outstanding deductible amount due, CPT will collect at each scheduled visit, either your applicable co-pay/co-insurance amount or $15.00 whichever is greater. This amount may not cover the total amount due for each visit; this amount is taken to offset the final balance and will be credited toward your total responsibility.

CANCELLATION/"NO SHOW" POLICY

A $20.00 fee will be charged to you for each appointment that is scheduled for you that you do not attend or that you cancel without 24 hours notice, this amount will be due at your next visit in addition to your regular co-pay, co-insurance or deductible payment. CPT reserves the right to waive this fee as a courtesy in the event of severe weather, health emergencies and other special circumstances.

This fee is NOT reimbursable by your insurance carrier.

I hereby verify that I have ***read and understand*** the above policy. I authorize Comprehensive Physical Therapy to release all information necessary to secure the payment of benefit and to use this signature on all insurance submissions .

Signature _____ **Date** _____

Print Name _____

Relationship to Patient _____

CPT ACCEPTS CASH, PERSONAL CHECK, VISA, MASTERCARD, AND DISCOVER FOR PAYMENT OF CO-PAYS, CO-INSURANCES AND OUTSTANDING DEDUCTIBLES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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*****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT*****

I am aware that the offices of Comprehensive Physical Therapy are adhering to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Practices . I have been given an opportunity to review the written policy .

_____

Please print name (Minor's name if applicable)

_____ _____

Signature (Parent/guardian if applicable) **Date**

What is the best way to contact you? (check all that apply) ☐ **Cell** ☐ **Home Phone** ☐ **E-Mail**

May we leave a voice mail? ☐ **YES** ☐ **NO**

May we leave a message with Family / Household Member? ☐ **YES** ☐ **NO**

If **YES** - Name(s): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because :

_____ **Individual refused to sign**

_____ **Communication barriers prohibited obtaining acknowledgment**

_____ **Other (Please Specify)**

_____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

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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.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI about you is maintained as a written and/or electronic record. Specifically, it individually identifies you and relates to (1) your past, present, or future physical or mental health; (2) related healthcare services; or (3) your past, present or future payment for your healthcare. We are required by law to maintain the privacy of your health information and provide you with a copy of this notice.

We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice, and make the revised or changed notice effective for all health information that we maintain. Any changes to this notice will be posted in our facilities and on our website. Paper copies will be available upon request.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:

FOR TREATMENT. We may use health information about you to provide, coordinate or manage your healthcare and related services. We may disclose health information about you to your doctor, staff or others who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition, which we may need to know about to determine the best plan of care.

FOR PAYMENT. We may use and disclose health information, as needed, about you so the treatment and services you receive may be billed, and payment may be collected from you, an insurance company or a third party. For example, this may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage of health benefits.

HEALTHCARE OPERATIONS. We may use or disclose, as-needed, your protected health information for our day-to-day health care operations to ensure that you and other patients receive quality care. For example, we may use or disclose PHI relating to the evaluation of patient care, business management activities, quality assessment and improvement, employee reviews, legal services, and auditing functions. All disclosures of your PHI will be limited to the minimum necessary or that which is contained in a limited data set (e.g. PHI that excludes certain identifiers including demographic information, photographs, et cetera).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

SPECIAL NOTICES. We may contact you at the address and phone number you provide (including leaving a voice message) about scheduled or canceled appointments, billing and/or payment matters. We may also contact you about health related services or Athletico locations that may be of interest to you.

REQUIRED BY LAW. We may use or disclose your health information when required to do so by federal or state law. We must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements under the Privacy Rule.

PUBLIC HEALTH RISKS. We may release your health information for public health activities. For example, disclosures related to the quality, safety or effectiveness of a product, prevention or disease control, to coroners, medical examiners and funeral directors as needed to perform their duties as required by law, and organ procurement organizations for the purpose of facilitating organ, eye or tissue donation and transplantation.

VICTIMS OF ABUSE, NEGLECT OR VIOLENCE. We may disclose your information to a government authority authorized by law to receive reports of abuse, neglect or violence relating to children or the elderly.

HEALTH OVERSIGHT ACTIVITIES. We may disclose your health information to health agencies authorized by law to conduct audits, investigations, inspections, licensure and other proceedings related to oversight of government regulatory programs.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS. We may disclose your health information in the course of an administrative or judicial proceeding in response to a court order. Under most circumstances, when the request is made through a subpoena, a discovery request, or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

LAW ENFORCEMENT. We may disclose your health information for law enforcement purposes.

RESEARCH. Your health information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of a particular person or the general public.

SPECIALIZED GOVERNMENT FUNCTIONS. We may disclose health information for military and veterans' affairs, or national security and intelligence activities.

WORKER'S COMPENSATION. Both state and federal law allow, without your authorization, the disclosure of your health information that is reasonably related to a worker's compensation injury. These programs may provide benefits for work-related injuries or illness.

OTHERS INVOLVED IN YOUR HEALTHCARE. Unless you object, we may disclose to a family member, relative or close friend your PHI that directly relates to that person's involvement in your care. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of PHI.

BUSINESS ASSOCIATES. We may disclose PHI to our business associates who perform functions on our behalf or provide us services if the PHI is necessary for those functions or services. For example, we may use a shredding company to destroy paper medical records. To protect your health information, we require the business associate to appropriately safeguard your information.

INFORMATION NOT PERSONALLY IDENTIFIABLE. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

NON-CUSTODIAL PARENT. We may disclose PHI about a minor equally to the custodial and non-custodial parent unless a court order limits the non-custodial parent's access to the information.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION: If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. Your decision to revoke authorization will not affect or reverse any use or disclosure that occurred before you notified us of your decision.

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH, AND GENETIC INFORMATION: Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Please contact our Manager of Privacy and Compliance for more information.

YOUR HEALTH INFORMATION RIGHTS: You have the right to inspect and copy your protected health information. You have the right to inspect and obtain a copy of your healthcare information. This includes health and billing records. Your request to inspect and obtain a copy of your healthcare information must be made in writing to: CPT - Medical Records Clerk, CPT, 421 Main Street, Forest City, PA 18421 In addition, we may charge you a reasonable fee to cover our expenses for copying your health information.

We may deny your request to inspect and copy your PHI in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who participated in the original decision to deny the request for access.

RIGHT TO AN ELECTRONIC COPY OF ELECTRONIC MEDICAL RECORDS. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request an electronic copy of your record be given to you or transmitted to another individual or entity.

RIGHT TO RECEIVE A SECURITY BREACH NOTICE. You have the right to receive written notification if Athletico discovers a breach of unsecured PHI, and determines through a risk assessment that notification is required.

YOU HAVE THE RIGHT TO REQUEST AN AMENDMENT TO YOUR PROTECTED HEALTH INFORMATION. If you believe the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. An amendment request must be made in writing, and must provide reasons to support your request. In certain cases we may deny your request for an amendment if: Your request is not in writing or does not include reasons to support the request; the medical record was not created by us, the person who created the information is no longer available to make the amendment, the record is not part of the health information we maintain, is not part of the information which you would be permitted to inspect and copy, or is accurate and complete.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to family members or friends who may be involved in your care or payment for your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your requested restriction. If we agree, we will comply unless we terminate our agreement or the information is needed to provide emergency treatment to you.

OUT-OF-POCKET PAYMENTS. If you paid out-of-pocket in full for a specific item or service, you have the right to request that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. We are required to agree to your request.

YOU HAVE THE RIGHT TO REQUEST THAT YOU RECEIVE CONFIDENTIAL COMMUNICATIONS. You have the right to request confidential communication from us by alternate means or at an alternate location. For example, you may ask that we only contact you at work or by mail.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES. You have the right to receive a list of disclosures of your PHI that we have made, except for disclosures pursuant to an authorization, for purposes of treatment, payment, healthcare operations, or required by law. Your request must state a time period which may not be longer than 6 years before your request.

You have the right to obtain a paper copy of this notice, even if you agreed to receive the notice electronically.

HOW TO EXERCISE YOUR RIGHTS: To exercise your rights described in this notice, you must submit your request in writing to:
CPT, 421 Main Street, Forest City, PA 18421

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our practice. We request that you file your complaint in writing so we may better assist in the investigation of your complaint. Send your written complaint to: Manager of Privacy and Compliance, CPT, 421 Main Street, Forest City, PA 18421.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Washington D.C. 20201, or the Illinois regional office of the Office for Civil Rights at: Office for Civil Rights, U.S. Department of Health and Human Services, 233 North Michigan Avenue, Suite 240, Chicago, IL 60601. Additional information can also be found on their website at www.hhs.gov/ocr/hipaa/.

You will not be penalized or otherwise retaliated against for filing a complaint.

If you want more information about our privacy practices or have questions please contact:

Manager of Privacy & Compliance
CPT, 354 Main Street, Forest City, PA 18421
Phone: 570-785-2018

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