SCHUYLERVILLE
Physical Therapy
Orthopaedic & Sports Rehabilitation

Notice of Payment Information Practices

This notice describes how medical and personal information about you may be used or disclosed and how you can obtain access to information. Please review this form carefully.

OUR LEGAL DUTY

Schuylerville Physical Therapy, PC uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, In any other situation Schuylerville Physical Therapy, PC will obtain your written consent and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosures at any time.

PATIENT 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 inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your health information for reasons other than for treatment, payment, or other related administrative purposes. You may request in writing that we not use or disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Schuylerville Physical Therapy, PC will consider all such requests on a case-by-case basis.

CONCERNS AND COMPLAINTS

If you are concerned that Schuylerville Physical Therapy, PC 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 discuss with Jeffrey B. Fear.

HIPPA DOCUMENTATION

1. I acknowledge that I have been given the opportunity to read and/or receive a copy of Schuylerville Physical Therapy, PC's Privacy Notice. _____ Yes _____No

1. Leave appointment message on:

Answering Machine? ___ Y ___ N
Office Voice Mail? ___ Y ___ N
w/ Person Listed Below? ___ Y ___ N
Cell Phone? ___ Y ___ N

Leave other medical info on:

Answering Machine? ___ Y ___ N
Office Voice Mail? ___ Y ___ N
w/ Person Listed Below? ___ Y ___ N
Cell Phone? ___ Y ___ N

3. Person(s) authorized to discuss the above and relationship:

_____

_____

Signature:_____ Date:_____

I consent to have the practice use and disclose my protected health information for payment, treatment and health care operation purposes, and for such other purposes that are permitted under HIPPA or other federal or state law without my written authorization.

Signature:_____ Date:_____

I authorize the payment of medical benefits to above state physician or supplier for services rendered.

Signature:_____ Date:_____

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