Notice of Protected Health Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE:

Monarch Physical Therapy, PLLC (MPT) is permitted by federal law to make uses and disclose your personal health information as it pertains to treatment, payment and health care operations. Protected health information that MPT has is the information that has been gathered during your course of treatment as a patient. This includes but is not limited to; documentation of symptoms, examinations, test results, diagnoses, treatment, applying for future care and treatment and billing documents for these services.

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

1. Treatment – MPT may disclose your protected health information in the coordination of your health care, i.e. contacting a specialist to discuss your treatment, your primary care physician or other medical personnel involved in your care.
2. Payment - MPT is permitted to disclose you protected personal health information for the purpose of billing, determining coverage, claims management, medical data processing and reimbursement.
3. Health Care Operations - MPT is permitted to use and disclose your healthcare information during MPT's routine healthcare operations including but not limited to; quality assurance, utilization reviews, medical reviews, auditing, accreditation, licensing or credentialing activities, legal services, protocol and clinical guideline development and for educational purposes.

USES AND DISCLOSURES WITH PATIENT AUTHORIZATION:

1. Under Privacy Regulations, MPT may use and/or disclose your health care information with your written
authorization. This may be necessary in cases of disclosing your name and medical condition to medical companies that may be able to provide useful services or equipment. You, the patient, may revoke this authorization at any time but it will not revoke any information given out prior to the receipt of revocation.

USES AND DISCLOSURES WITH PATIENT OPPORTUNITY TO VERBALLY AGREE OR OBJECT:

1. MPT, under the privacy regulations, is permitted to share your information without written consent to family members, caregivers, a close personal friend or any other person identified by you, if the information is directly involved in that person's involvement in your care or treatment. Notification in advance is required by MPT and you, the patient, have the opportunity to verbal consent or deny.

USES AND DISCLOSURES WITHOUT AN ACKNOWLEDGEMENT, AUTHORIZATION, OR OPPORTUNITY TO VERBALLY CONSENT OR OBJECT:

1. Under the Privacy Regulations we are able to provide your protected health information in the following cases without your acknowledgement, authorization or opportunity to obtain verbal permission:

- Uses and Disclosures Required by Law
- Abuse and/or Neglect – In such cases where abuse and/or neglect is reasonably suspected your health information may be shared
- Public Health Activities – MPT may disclose your protected health information in the event of reporting communicable diseases, vital statistics, public health reporting and other similar circumstances.
- Regulatory Agencies - MPT may disclose your information to a health care oversight agency for activities authorized by law including but not limited to licensure, certification, audits, investigations, and inspections. These programs are essential for the monitoring of civil rights compliance, monitoring the health care system and government programs.
- Law Enforcement Purposes - MPT may disclose your protected health information to law enforcement when required to do so.
- Judicial and Administrative Proceedings - MPT may disclosure protected health information in judicial and administrative proceedings, in response to a court order, administrative tribunal, or in response to a summons, warrant, subpoena, discovery request or other legal requests.
- Coroners, Medical Examiners and Funeral Directors
- Research - When appropriate, MPT may disclose you personal protected health information to researchers when their study has been approved by an institutional review board that has reviewed the research proposal and has made certain safeguards are in place to protect your health information.
- Threats to Health and Safety
- Military/Veterans - If you are a member of the armed forces we may disclose your health information as required by commanding military authorities.
- Workers' Compensation - TPPT may disclosure your health information in order to be compliant with laws relating to workers' compensation and other similar programs.
- Marketing - MPT may disclose your information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services of a nominal value, or identifies us as the communicating party and that we will receive remuneration for receiving for making the communication and, where required by the

Privacy Regulations, instructions describing how you may verbally object to receiving future communications.
- Appointment Reminders - MPT may use and disclose your private protected health information to remind of an appointment for treatment and medical care at MPT.
- Other uses and disclosures - In addition to the reasons listed above we may use and disclose you health information for other purposes as defined by the Privacy Regulations.

USES AND DISCLOSURES TO BUSINESS ASSOCIATES:

1. With proper authorization, we are permitted to disclose your health information to business associates and to allow business associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity, which requires the use of your health information. Examples include, lawyers, accountants, medical billing facilities and others. Each is required to protect your private health information.

PATIENT RIGHTS
Although your health information is our property, you have the following rights regarding your health information:

1. Right to request restrictions on the use and disclosure of your health information: You have right to request in writing restrictions on disclosure of your health information as it pertains to health care operations, treatment and payment. MPT, however, does not need to comply with such requests.
2. Right to inspect and copy your health information: You have the right to inspect your health care record upon request. For example this does not extend to psychotherapy notes, information compiled in reasonable anticipation of a civil or criminal proceeding. Access may also be denied if a threat is perceived to you or someone else.
3. Right to verbally object
4. Right to seek amendment of your health information: You have the right to request in writing an amendment of your health information. MPT has the right to deny such request but must give you a written explanation.
5. Right to an Accounting of disclosure of your health information : You have the right to request an accounting of disclosure made by us of your disclosure of your health information within six (6) years of the date requested. The accounting will not include disclosures for treatment, billing, payment or health care operations. The accounting disclosures will include the date, name, address, description of the information disclosed and purpose of disclosure.
6. Right to confidential communications
7. Right to revoke Authorization
8. Right to receive copy of this notice

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHT VIOLATION

If you would like to additional information and/or have questions regarding the uses and disclosures of your health information please contact MPT. MPT has established an internal complaint process for reporting privacy rights violations. If you believe your rights have been violated you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Ave, S.W., Washington, DC, 20201. To file a complaint with us you may contact the address provided. All complaints must be submitted in writing to 518 S Main St, Unit A, Hatfield, PA 19440. There will be no retaliation for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT PRIVACY NOTICE

I acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Monarch Physical Therapy, PLLC (MPT) for the purpose of treatment, obtaining payment and other health care operations permitted by the privacy act.

I acknowledge that I have received a copy of the privacy notice.

I acknowledge and understand that MPT has the right to change its privacy notice as it sees fit from time to time. If I wish to obtain an updated privacy notice I need to send a written request to 518 S Main St, Unit A, Hatfield, PA, 19440 Attention: Practice Compliance Director.

I understand that I may request restrictions be placed on the use and disclosure of my health information but that MPT does not have to agree to this request.

I request the following restrictions be placed on the use and disclosure of my health information (leave blank if no restrictions):

____
____
____
____

For further information on our health information practices, please contact Luke Pedersen, owner of Monarch Physical Therapy, PLLC at luke@monarchphysicaltherapy.com.

I have read, acknowledge and understand the policies set forth in the above privacy notice.

Patient/Guardian Signature:_________________________________Date: ____/_____/_____

Date: ______ / ______ / _______

First Name_______________________

Last name ______________________________ MI ______

Birth Date _____ / _____ / _______ Sex: M F (please circle)

Address ____

City ____________________

State ______ Zip ___________

Email Address ____

Home Phone (______) - ______ - ____________

Cell (______) - ______ - _______________

Work (______) - ______ - ______________

Can we leave a message on: _____Phone _____Text _____Email

Emergency Contact ___________________________

Phone (______) - ______ - ____________

Relationship __________________

Current Employer ____

Occupation ____________________________________

Were you injured on the job? Yes No Date of injury ______ / ______ / ______

Were you injured in a car accident? Yes No Date of injury______ / ______ / ______

Are you a Medicare or Medicaid Beneficiary? Yes / No

Payment is expected at the time services are rendered. If you need to make special payment arrangements, please notify us at the onset of your treatment.

All past balances must be paid in full before receiving further physical therapy treatment from Monarch Physical Therapy, PLLC.

Balances remaining after 60 days, which are not being actively paid on, are subject to a 1.5% interest charge per month. All balances not being actively paid on will be sent to a collections agency at 90 days. Upon submission to a collection agency it will be the patient or guarantors responsibility to pay all collection and legal fees incurred by our office while collecting the outstanding balance.

I, ____________________________________, have read and understand all guarantees and financial policies above.

Patient/Guardian Signature __________________________ Date ______ / ______ / ______

(Person responsible for the bill and/or Legal Guardian if Patient is under the age of 18)

PATIENT AUTHORIZATION AND CONSENT

Patient Name:

I hereby consent to treatment procedures and patient care deemed necessary by my physical therapists while I am a patient of Monarch Physical Therapy, PLLC

I authorize Monarch Physical Therapy, PLLC and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

I have received Monarch Physical Therapy, PLLC's Notice of Information Practices. I understand that Monarch Physical Therapy, PLLC and its subsidiaries and affiliates may use or disclose my personal health information to my insurance company, rehab nurse, case manager, attorney, employer, school, relate healthcare provider, assignees and/or beneficiaries and all other relates persons as it relates to my treatment. I understand that I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that Monarch Physical Therapy, PLLC will consider requests on a case-by-case basis, but does not have to agree to requests for restrictions.

Non-Discrimination
Monarch Physical Therapy, PLLC Inc and the patient agree that services will be rendered to each individual regardless of race, color, sex, age, national origin or handicap.

Authorization of Phone Contact
I hereby authorize the staff of Monarch Physical Therapy, PLLC to leave messages on my answering machine/voicemail pertaining to billing information, confirmation of appointments or the need for future scheduling. I also allow the staff to leave these messages with a family member.

I hereby authorize one or all of the designated parties below to request the release of and receive any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name & Relationship:____
Name & Relationship:____
Name & Relationship:____
Name & Relationship:____

Payment Guarantee: I agree to pay Monarch Physical Therapy, PLLC its subsidiaries and/or affiliates for the services provided to me or the party named above. Where the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Monarch Physical Therapy, PLLC and/or its affiliates or subsidiaries.

Patient/Guardian Signature: ____________________________ Date: ____ / ____ /_____

PAST MEDICAL HISTORY

Name: ____

Age:_____ Sex: ______ Height:________ Weight:_________

Reason for Therapy:____

Referring Doctor:____

Primary Doctor:____

Who may we thank for referring you to Monarch Physical Therapy?________________

Date Of Injury/Onset of Condition:______________
Describe the nature of your injury or condition?________________________________
____
____
____

What relieves your symptoms?____

What aggravates your symptoms?____

Have you received treatment for this condition before? ________

Have you received physical therapy for this condition before?_________

Is so, what treatment did you receive and was it successful?______________________
____
____

Please rate your pain between 0 and 10 (0 is no pain, 10 is likened to childbirth or passing a kidney stone)

At worst _____ Present ______ At best ______

Do you now, or have you in the past, had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes			Current Infections			Previous Fractures		
Arthritis			Heat/Cold Hypersensitivity			Osteoporosis		
High Blood Pressure			Allergies			Depression		
Heart Disease			Hernia			Anxiety		
Heart Attack			Presently Pregnant			Substance Abuse		
Pacemaker			Seizures			Dizziness/Falls		
Vascular Disease			Metal in Body			Tobacco Use		
Headaches			Cancer/Tumor			Alcohol Use		
Kidney Problems			Thyroid Problems			Previous Surgeries		
Open Wounds			CVA/Stroke			Other		

If you answered yes to any of the above, please explain and give approximate dates:

____

____

____

____

Are you pregnant? Yes / No How Many Weeks?

Do you smoke? Yes / No How many packs?

Did you have surgery? Yes / No Details:

Frequent nausea/vomiting? Yes / No Details:

Unexplained weight loss? Yes / No Details:

Numbness/tingling? Yes / No Details:

Changes in Bowel or Bladder? Yes / No Details:

Please list results of any diagnostic tests (x-rays, MRI, CT scan, EMG, etc):

____
____
____

Please list all current medications (prescriptions, over-the-counter, herbals, vitamins/minerals/dietary/nutritional supplements):

____
____
____
____
____
____

The information above is correct to the best of my knowledge. If anything changes, I agree to notify Monarch Physical Therapy, PLLC and update this form.

Patient/Guardian Signature: ________________________________ Date:_____________

Pain Drawing

Relating to your present injury or condition

Indicate where your pain is located and what type of pain you feel at the present time.
Use the symbols below to describe your pain.

/ / / / Stabbing   X X X Burning   O O O Pins and Needles   === Numbness