Patient and Doctor of Physical Therapy Contract

Contract between ______________________ and ______________________ PT, DPT

Fill In with Your Physical Therapist

We want you to achieve your goals and get the most out of therapy; this requires regular, consistent attendance. For this reason, we have enacted a contract between you ("The Patient"), and FYZICAL Therapy & Balance Centers of Oklahoma City ("FYZICAL") to ensure that we can help you achieve your goals.

Physical therapy (PT) is an intervention that increases movement, improves musculoskeletal health, enhances balance and prevents falls, and optimizes your physical functioning. Unlike many medications, physical therapy is meant to be a highly concentrated dose over a short period to cure the physical challenges you are facing. However, much like a doctor prescribes a medication, your physical therapist will prescribe activities and exercises to improve your overall physical health. PT is most effective when you make your appointments and follow your home exercise program.

Three goals for physical therapy:

1. ____
____
2. ____
____
3. ____
____

We strive to provide one-on-one service; however, this requires that you keep your appointments and give us at least 24 hours' notice to reschedule you. As such we have a strict 24-hour cancellation policy. You will be charged **$75** for each cancellation with less than 24 hours notice.

__________ Please Initial — I understand and agree to Fyzical's cancellation policy. I agree to show up to my appointments on time. I understand that if I am late, I may not get my full treatment time, which may reduce the effectiveness of physical therapy.

__________ Please Initial — I agree to perform my PT exercises at home to the best of my ability to meet my PT goals.

__________ Please Initial — I agree to ask questions if I do not understand why I'm doing my exercises or what my exercise activities are achieving.

__________ Please Initial — I understand that based on my initial evaluation my plan of care should take between _____ and _____ sessions. I also understand this may be revised based on my success in progress at my re-evaluation which is planned for visit _____.

______________________________ ______________________________
Patient Signature Date Physical Therapist Signature Date

Thank you! We Look forward to helping you Love Your Life!

Patient Information & Patient Agreement

Patient Name: ____ Date of Birth: ___________________

Consent for Treatment: I hereby consent to receive care for therapy services by FYZICAL. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

Disclosure of Information: I understand that my medical records and billing information made and retained by FYZICAL are accessible to office personnel. Office Practice/Clinical personnel may use and disclose medical information for operations functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. FYZICAL and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of FYZICAL's charges and to any health care provider who is or may become involved with my care. Oklahoma law requires FYZICAL advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, I consent to such disclosure. FYZICAL personnel may release my general condition to family or friends inquiring about me by name.

Assignment of Insurance Benefits: I agree that therapist benefits otherwise payable to the insured are to be made payable to the therapist(s) responsible for my care.

Insurance Billing: I request all bills be processed through my insurance carrier. I understand that by requesting insurance billing, the self-pay rate is not available to me. I understand that if insurance denies a claim, I will be responsible for the full amount, and that this will not apply toward my deductible. I acknowledge that the self-pay rate is highly discounted. I acknowledge that once insurance is billed, accepts the claim, and puts the billed amount towards my out-of-pocket costs, I will owe the amount according to my insurance company's agreed fee schedule.

OR

I request self-pay of all appointments at the rate of $125 for the initial evaluation and $80 for each subsequent visit. Patient Signature: _____________________ Date: _________

Financial Responsibility and Timely Payment: I understand that I am responsible for paying all charges not covered by my insurance, on the date services are rendered (including, but not limited to, co-pays, estimated deductibles and estimated co-insurance). I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection fees. If insurance is being filed, non-met payments are due within 15 days of receiving the bill or subject to $5/day late fee. I understand that fees are subject to change at the discretion of the practice and that a fee schedule is available upon request. I understand there is a $35 administration charge for checks that do not clear the bank.

I understand that it is my responsibility to know the benefits of my insurance policy and to verify Physical Therapy coverage. I understand that FYZICAL may do a courtesy check prior to my assessment. I understand that should a dispute arise, on a claim, it is my responsibility to clarify and resolve the dispute with my insurance company.

Communication: I understand that phone calls are not billable to my insurance. I understand that emails and phone calls will be returned within 72 hours. I understand that appointments can be made via phone calls, in-person, or online (with confirmation) only.

Certification

I hereby certify that I have read the statements above, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this agreement. A photocopy of this document has the same effect as an original.

Patient (or Legal Representative) Signature: __________________________ Date: ____________

Relationship to patient: _________________________

Office Staff Signature: __________________________________ Date: ___________

Acknowledgement of Notice of Privacy Practices

A complete description of how your medical information will be used and disclosed by FYZICAL is in our Notice of Privacy Practices, which you have received. A copy is posted in the office.

I have received a copy of Notice of Privacy Practices.

Patient (or Legal Representative) Signature: ___________________________ Date: ____________

Relationship to patient: __________________________

Office Staff Signature: ___________________________________ Date: ___________

Authorization for Release of Verbal Communication AND Exchange of Written Information

1. Patient Information

Name – Last, First, MI		Date of Birth	
Street Address	City	State	Zip Code
Phone Number			

2. Exchange of Information Between:

Name: FYZICAL Therapy & Balance Centers of Oklahoma City		
Address: 7415 N May Ave		
City: Oklahoma City	State: OK	Zip Code: 73116
Phone Number: (405) 400-8909	Fax: (405) 400-8949	

3. And: (Only one person/organization per authorization)

PHYSICIAN

Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax:	

4. ☒ **Insert Written Medical Record Documentation to be Disclosed:** Includes ANY and ALL records unless otherwise specified below:
   Records pertaining to (dates or conditions): ____
   Other (describe): ____
5. ☒ **Exchange of Verbal Communication between those listed in Sections 2 & 3**
6. ☐ Additional option to leave **VOICE MAIL** to those listed in Section 3 Voice mail includes any information unless specified:
   ____
7. **Purpose or need for disclosure:** Care Coordination unless otherwise specified:
   ____
8. **This authorization will expire** one year from signature unless otherwise indicated below:
   ☐ Other specific expiration date (specify): ______/______/______

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information. This authorization includes disclosure of information regarding substance use disorder, psychiatric consults and mental illness, developmental disabilities, genetic testing, AIDS or AIDS-related illness, sexually transmitted infection, and/or HIV test results, unless I limit the disclosure to exclude the following:

____

____

Signature of Patient/Representative: ____ **Date:** ____/____/____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: ______________________________________ Relationship: ____________________________

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I understand that if I am referred to physical therapy for pelvic floor dysfunction, it may be beneficial for my therapist to perform a muscle assessment of the pelvic floor, initially and periodically to assess muscle strength, length, and range of motion and scar mobility. Palpation of these muscles is most direct and accessible if done via the vagina and/or rectum. Pelvic floor dysfunctions include: pelvic pain syndromes, urinary incontinence, fecal incontinence, dyspareunia or pain with intercourse, pain from an episiotomy or scarring, vulvodynia, vestibulitis or other complications. Evaluation of my condition may include observation, soft tissue mobilization, use of vaginal cones, and vaginal or rectal sensors for biofeedback and/or electrical stimulation.

I understand that the benefits of the vaginal/rectal assessments will be explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

Treatment procedures for pelvic floor dysfunctions include without limitation: education, exercise, stimulation, ultrasound, use of vaginal weights, and several manual techniques including massage, joint and soft tissue mobilization. The therapist will explain all of these treatment procedures to me, and I may choose to not participate with all or part of the treatment plan. I understand that no guarantees have been or can be provided to me regarding the success of therapy.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits, and alternatives of the treatment.

Based on the information I have received from the therapist; I voluntarily agree to standard assessment and muscular treatment techniques of the perineal area. (Please Initial One)

_______ I am comfortable with only the therapist performing the evaluation in the room

_______ I would prefer to have a chaperone in the room while the therapist performs the evaluation (please note the chaperone must be provided by the patient).

Patient Signature: ____________________________________ Date: ____________

Therapist Signature: __________________________________ Date: ____________

*** If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity to KY Jelly, vaginal creams or latex, please inform the therapist prior to pelvic floor assessment.

- **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. We may deny you the request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **Right to Get Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured PHI.
- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or healthcare operations where an authorization was not required.
- **Request Restrictions:** 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 someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we do not disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Out-of-Pocket Payments:** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask 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, and we will honor that request.
- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of your home. The facility will grant requests for confidential communications as alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of this Notice:** You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
- **Right to an Electronic Copy of Electronic Medical Records:** If your PHI is maintained in an electronic format you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be elective for information we already have about you as well as any information we receive in the future. The current notice will be posted and include the elective date. In addition, each time you register for treatment or healthcare services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in the office or clinic.

Phone: (405) 400-8909

Fax: (405) 400-8949

www.FYZICAL.com/Oklahoma-City

NOTICE OF PRIVACY PRACTICES

Effective Date: October 1, 2018

HIPAA

Health Insurance Portability and Accountability Act

This notice describes how health information about you may be used and disclosed, as well as how you can get access to this information.

Please review it carefully.

If you have any questions about this notice, please contact the Office Manager.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, and treatment, a plan for future care or treatment, and billing related information. This notice applies to all of the records of your care generated, whether made by personnel or agents for the clinic.

Our Responsibilities:

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures:

How we may use and disclose Health Information about you:

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other clinical personnel who are involved in taking care of you at the clinic. We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating of once you are discharged.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your progress so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether it is a covered service under your plan

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may also combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes.

Marketing & Any Purposes which Require the Sale of Your Information: The following uses and disclosures of your PHI will be made only with your written authorization: **1)** Uses and disclosures of PHI for marketing purposes; and **2)** Disclosures that constitute a sale of your PHI. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization.

We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To business associates we have contracted with to perform agreed upon services and billing for these services;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To contact you as part of fundraising efforts; however, you have the right to Opt out;
- For population based activities relating to improving health or reducing healthcare costs; and
- For conducting training programs or reviewing competence of healthcare professionals.

When disclosing information, primary appointment reminders and billing/collections efforts, we may leave messages on your answering machine or voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do, as well as bill you, your insurance company, or a third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Individuals Involved in your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in disaster relief effort so that your family can be notified about your condition, status and location.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Future Communications: We may communicate to you via email, newsletters, and mailings or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based programs.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and healthcare operations.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health of Legal Authorities charged with preventing or controlling disease, injury or disability.
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing healthcare costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.