Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip:_____

Date of Birth: _____ Sex: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician / Family Doctor(s): _____

Are you currently under the care of a Home Health Agency? ____ No ___Yes, name of Co. _____

How did you hear about FYZICAL? _____

If Patient is a Minor

Responsible party for bill if other than patient: _____ Relationship: _____

Responsible party's address (if other than above): _____

Date of Birth: _____ Social Security Number: _____

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.

Consent to Release Medical Information:
I authorize FYZICAL to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurances(s), physician(s) and _____

Consent to Obtain Medical Information:
I authorize FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans and MRI reports, along with my Physician's Documentation.

Assignment of Insurance Benefits:
I hereby authorize payment to be made directly to FYZICAL.

Guarantee of Payment:
I agree to pay any charges that my insurance does not pay. I am responsible to pay any uncovered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees and collection agency fees.

I acknowledge that I have received the Notice of Privacy Practices for Protective Health Information.
I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature: _____ Date: _____

Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact and/or by contact with contaminated surfaces and objects, and even possibly in the air. People reportedly can be infected and show no symptoms and therefore spread the disease. The exact methods of spread and contraction are unknown, and there is no known treatment, cure, or vaccine for COVID-19. Evidence has shown that COVID-19 can cause serious and potentially life threatening illness and even death.

***Clifford Milowicki Physical Therapy Services dba FYZICAL Therapy & Balance Centers* cannot prevent you [or your child(ren)] from becoming exposed to, contracting, or spreading COVID-19 while utilizing FYZICAL Therapy & Balance Centers' services or premises. It is not possible to prevent against the presence of the disease. Therefore, if you choose to utilize FYZICAL Therapy & Balance Centers' services and/or enter onto FYZICAL Therapy & Balance Centers' premises you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19.**

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself and/or my children in order to utilize FYZICAL Therapy & Balance Centers' services and enter FYZICAL Therapy & Balance Centers' premises. These services are of such value to me [and/or to my children,] that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to utilize FYZICAL Therapy & Balance Centers' services and premises in person rather than arranging for an alternative method of enjoying the same services virtually (e.g. videoconference).

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against FYZICAL Therapy & Balance Centers and its owners, officers, directors, managers, officials, trustees, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to utilizing FYZICAL Therapy & Balance Centers' services and premises. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

CHOICE OF LAW: I understand and agree that the law of the State of Pennsylvania will apply to this contract.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE:

Signature: _____ Date: _____

Name (printed): _____

I am the parent or legal guardian of the minor named above. I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this Release.

Signature:_____ Date: _____

Name (printed): _____

CLIFFORD MILOWICKI PHYSICAL THERAPY SERVICES
dba FYZICAL Therapy & Balance Center
Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A staff member obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

• Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;

• Obtain a paper copy of this Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;

• Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;

• Appeal a denial of access to your protected health information except in certain circumstances;

• Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;

• File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;

• Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;

Notice of Privacy Practices for Protected Health Information

• Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
• Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact**,** in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights.
You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Our Responsibilities
The practice is required to:
• Maintain the privacy of your health information as required by law;
• Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
• Abide by the terms of this Notice;
• Notify you if we cannot accommodate a requested restriction or request; and
• Accommodate your reasonable requests regarding methods to communicate health information with you.
We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.
To Request Information or File a Complaint
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact:

Clifford Milowicki Physical Therapy Services dba FYZICAL Therapy & Balance Centers
2001 Waterdam Plaza Drive
Suite 102
McMurray, PA 15317
Phone 724-941-7070

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to:

Todd Exley (Managing Partner) or Anne Veres (Compliance Officer) at the above address.

You may also file a complaint by calling the Secretary of Health and Human Services – 1-877-724-3258

•We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
•We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Effective Date: January 1, 2020