ATLANTA
PHYSICAL THERAPY LLC

Phone:(404)390-0255| Fax:(404)393-8015 | 338 Hillcrest Ave Apt E, Decatur, GA 30030 | Nick@PhysicalTherapyATL.com

— Physical Therapy Services Policies & Procedures —

Welcome to Atlanta Physical Therapy LLC ("Atlanta PT"). Please carefully review, initial, and sign these policies and procedures. They set forth the terms of our relationship as you receive physical therapy from Atlanta PT.

Communication

Please tell us how you would like us to communicate with you. By authorizing us to communicate with you by email or text message (signified by checking the corresponding box(es) below) or by communicating with us by email or text message, you agree to receive unencrypted emails and text messages from Atlanta PT, which may not be secure.

Email Address: ____

Cell Phone: __________________ **Okay to leave voicemail?** Yes ☐ No ☐

Work Phone: _________________ **Okay to leave voicemail?** Yes ☐ No ☐

Other Phone: ________________ **Okay to leave voicemail?** Yes ☐ No ☐

Please tell us how we may communicate with you.

	Work Phone	Cell Phone	Email	Mail
Information about your care & treatment	☐	☐	☐	
Appointment reminders	☐	☐	☐	
Practice announcements & marketing	☐	☐	☐	☐
Billing information			☐	☐

I acknowledge and agree to this policy. __________ *(initial)*

Medical Records Request Policy

We maintain records about your treatment at Atlanta PT. To obtain a copy of your records, please submit a written request on the form that we provide, including your full name, date of birth, date of request, and signature. Please also specify to whom you want your records sent, their address, and the reason for your request. Please note that in some instances we may charge a reasonable and cost-based copying, postage, shipping, scanning, or digital storage device fees.

I acknowledge and agree to this policy. _________ *(initial)*

HIPAA

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information. As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information. We may use and disclosed your medical records only for each of the following purposes: treatment, payment and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
• Payment means such activities as obtained reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
¥ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
¥ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
¥ The right to inspect and copy your protected health information.
¥ The right to amend your protected health information.
¥ The right to receive an accounting of disclosures of protected health information.
¥ The right to obtain a paper copy of this notice from us upon request.
We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 1st, 2018 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775

I acknowledge and agree to this policy. __________ *(initial)*

Indemnification & Assumption of Risk

As a condition of receiving physical therapy services from Atlanta PT, to the greatest extent permitted by law, you agree to indemnify us against all claims, liabilities, losses, damages, suits, costs, and expenses (including reasonable attorney's fees) relating to our physical therapy services to you. You agree to assume all risk of property damage, injury, or death associated with any physical therapy provided to you.

We will discuss the anticipated risks and benefits of, and alternatives to, your planned treatment, and you will have an opportunity to ask questions. The terms of this indemnification and assumption of risk policy shall survive the expiration date of any treatment.

I acknowledge and agree to this policy. __________ *(initial)*

Health Information Authorization for Care Purposes

I, the undersigned, authorize disclosure and use of my health information to the extent necessary to coordinate care with my primary care physician or other treating provider. I understand that I may revoke this authorization at any time by providing written notice to Atlanta PT, except to the extent that Atlanta PT has relied upon it.

I acknowledge and agree to this policy. __________ *(initial)*

Self-Payment & Payment Guarantee

For any returned check, you agree to pay: your entire balance due, any returned check fees, and a $25.00 charge for Atlanta PT's billing services management of the situation. You authorize such charges to the credit card provided below. Please complete the following credit card authorization to cover any cancellation fees and returned check fees. We will save to our file the below credit card information for future charges.

Name on Card: ____
Phone: ________________ Email: ______________________________

Type of Card: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other: ______

Card Number: ___________________ Exp. Date: ___________ CVC: ________

Card Billing Address (Street/City/State/Zip): _______________________

____

The cardholder hereby authorizes the above credit card to be charged for agreed purchases or services, cancellation, and returned check charges, and to be saved to our file:

Signature: _____________________ **Date:** ___________

Cancellation & Attendance

If you need to cancel or reschedule your appointment, you must contact us no later than 12:00 p.m. on the business day (Monday through Friday) prior to your schedule appointment to avoid a $30.00 late cancellation fee. For Monday appointments, you must cancel by 12:00 p.m. on the previous Friday. If you cancel without providing the proper notice, you must pay any late cancellation charges immediately and prior to resuming any treatment.

I acknowledge and agree to this policy. _________ *(initial)*

Acknowledgement & Agreement

I, the undersigned, hereby acknowledge and agree that:

- I have read and understand these Physical Therapy Services Policies & Procedures, and I have truthfully and to the best of my knowledge provided the information requested;
- I am bound by these Physical Therapy Services Policies & Procedures;
- I authorize the use of my health information as provided herein;
- I shall indemnify Atlanta PT and its providers; and
- I voluntarily assume all risks of treatment.

My Name: ___________________ **Signature:** ______________ **Date:** _____

If you are a minor (under 18 years old), please ask your parent or guardian to review this document and sign below.

I, the undersigned, am the parent or guardian of the above referenced patient. I have reviewed this document and agree to be bound by it on my behalf and on behalf of the patient.

My Name: ___________________ **Signature:** ______________ **Date:** _____

— For Atlanta PT's use only —

Initials of reviewing provider: _____________ *Date of review:* _______________

Did the patient have questions about these Physical Therapy Services Policies & Procedures? Yes ☐. No ☐. If yes, briefly note those questions: _______________
____

— Informed Consent for Physical Therapy —

Before we can treat you, we are required to obtain your informed consent to receive physical therapy services. You can only provide us with your informed consent after we have discussed our proposed treatment, the potential risks of that treatment, the potential benefits of that treatment, and information about any potential alternative treatments. Therefore, you, the undersigned patient, acknowledge and agree that Atlanta PT and its providers will render the physical therapy services described below. You consent to this treatment.

To Be Completed Together During Our First Visit

1) Summary of the physical services that we will provide.

2) Summary of the potential material risks, benefits, and alternatives.

Acknowledgement & Agreement

As provided above, my physical therapist has explained the services and treatments that I will receive, as well as their material risks and benefits. I agree and acknowledge that this treatment may not have the results that I expect or desire. My physical therapist has discussed with me other possible treatments that might provide me a benefit. Further, I agree and acknowledge that physical therapy is not an exact science, and I have not been given any guarantees about treatment.

To facilitate evaluation of my condition, it may be necessary for a provider of Atlanta PT to perform an internal pelvic floor exam, both during the initial evaluation and throughout treatment. I may have a second person present during treatment, but it is my responsibility provide such person, as Atlanta PT does not have staff available for this purpose.

My physical therapist has offered me ample time and opportunity to discuss my concerns, and all of my questions have been answered to my satisfaction.

My Name: ________________________ **Signature:** ______________________________
Date: _________

For minor patients: I, the undersigned, am this patient’s parent or guardian. I hereby provide my informed consent for the patient’s treatment, both on my behalf and on behalf of the minor patient.

My Name: ________________________ **Signature:** ______________________________
Date: _________