Notice of Privacy Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed. Please review it carefully!

The clinic is permitted by federal privacy laws to make use of and disclose 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. Below you will find examples of each scenario:

Uses of Your Health Information for Treatment Purposes are:

During the course of your treatment, the therapist determines, he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Uses of your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

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

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office—we are not required to grant the request, but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purpose of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;)
- Obtain a paper copy of the current 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 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 request to our office. We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that create the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for the office;
  - Is not part of the information that you would be permitted to inspect and copy;
  - Is accurate and complete.
- If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

Other Disclosures and Uses

- **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.
- **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.
- **Disaster Relief**: We may use and disclose your protected health information to assist in disaster relief efforts.
- **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 authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.
- **Abuse and Neglect**: We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.
- **Employers:** We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for release of that information to your employer.
- **Correctional Institutions**: If you are an inmate of a correctional institution, we may disclose to the institution or its agents the 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 prosecution, or at 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 authorization, or as directed by a proper court order.
- **Serious Threat**: To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
- **Coroners, Medical Examiners, and Funeral Directors**: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of covered entities to funeral directors as necessary for them to carry out their duties.

Payment Policy

Thank you for choosing us as your rehabilitation provider. We are committed to providing you with quality and affordable health care service. Below you will find our policy on patient and insurance responsibility for our clinic. Please read it, ask us any questions you may have, and sign in the space provided on the "New Patient Information Form." A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. In no way are any benefits quoted by Canyon Therapy a guarantee of coverage or payment by your insurance company. If your treatment is due to an Auto Accident, we can file it though your auto insurance carrier. This is acceptable if the auto insurance will be paying the claim as it accrues and does not delay payment until the case is settled.
2. **Co-payments and deductibles:** All co-payments must be paid at the time of service. Deductible amounts that are patient responsibility will be invoiced to the patient after insurance has processed your claims. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment and deductibles respectfully when due. Patient balances will be due in full at six months from the last date of service. If patient balance is not paid by that time, patient account will be sent to a collection agency, the patient will be responsible for cost of collection, including any attorney fees.
3. **Self-pay:** Canyon Therapy offers a self-pay option for patients that are un-insured. If you chose to pay for services through self-pay, charges are due on the date of service. Patient balances will be due in full at six months from the last date of service. If patient balance is not paid by that time, patient account will be sent to a collection agency. The patient will be responsible for cost of collection, including any attorney fees.
4. **Non-covered services:** Please be aware that some—and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be invoiced for these services after your insurance has processed your claims. You will be responsible for these charges in full.
5. **Proof of insurance:** all patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or other form of valid identification and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
6. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
7. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in a timely manner, the balance will automatically be billed to you.
8. **Nonpayment:** If your account is **over 150 days** past due from last date of service, you will receive a final notice invoice stating you have **30 days** to pay your account in **ful**l. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. In the event that your account does go to a collection agency, you will be responsible for any reasonable collection fees and/or attorney fees.

Thank you for understanding our payment policy. Please let us know if you have any questions of concerns.

CANYON THERAPY
Physical & Occupational Therapy
relief • recovery • results

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New Patient Information Form

*First Name:*________________________ *MI:*_____ *Last Name:*________________________

*Nickname (if applicable):*________________________ *Social Security #:*_______-_______-_______

Gender: ☐ M ☐ F *Date of Birth:*______-______ -______ *Marital Status:* S M D O

*Mailing Address:*________________________

*City:*________________________ *State:*____________ *Zip Code:*____________

*Home Phone:*____________ *Cell Phone:*____________ *Work Phone:*____________

How did you hear about Canyon Therapy?

☐ *Doctor* ☐ *Friend* ☐ *Previous Patient* ☐ *Radio* ☐ *Newspaper* ☐ *Phonebook*

*Employer:*________________________ *Occupation:*________________________

*Referring Doctor:*________________________ *Next DR. Appointment:*____________

*Primary Family Doctor:*________________________

*In Case of Emergency:*________________________

*Relationship to Patient:*________________________

Cell Phone: ________________________ *Work Phone:*________________________

*Date of Onset:*________________________ *Receiving Home Health?* *Y* *N*

Consent to treat: *I authorize Canyon Therapy to render services as deemed necessary for the care of the above named Patient and I read and understand the HIPAA Notice of Privacy Practices.*

Medical Release of Information: *I authorize Canyon Therapy to release any medical information necessary to process this claim.*

Assignment of Benefits: *I hereby assign payment directly to Canyon Therapy. My payment preference is given to the receptionist.*

Payment Policy: *I have read and understand the Canyon Therapy Payment Policy. For your convenience we accept Cash, Checks, and Credit Card. Self-pay and Co-Pays are collected at the time of service.*

ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, AND WILL BE RESPONSIBALE FOR ANY ATTORNEY FEES. I UNDERSTAND THAT MY INSURANCE BENEFITS AND REFERRAL REQUIREMENTS ARE MY RESPONSIBILITY AND THAT ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

*Patient/Guardian Signature:*________________________

*Date:*________________________

Insurance Information

Your Name: ______________________________ Birthday: ________________ Today's date: _______________

Primary Insurance: ____________________________ Insurance's Phone: __________________

Effective Date: ______________

Do you have Occupational and/or Physical Therapy Benefits? ___________

Copay: _$_______ visit

How much is your deductible? ________________________

How much of your deductible has been met? ___________________

What is your maximum out of pocket? ___________________

What % is paid be insurance after your deductible is met? ______________

Is an authorization or precertification required? __________________

Do you have any visit limitations on your policy? ___________________

How did you obtain this information? ________________________