MOBILE PHYSIO LLC

Notice and Acknowledgement of Receipt of Privacy Practices, Financial Agreement, and Consent for Treatment

The purpose of this form is to document that you have received, reviewed, and agree with Mobile Physio's Notice of Privacy Practices, Financial Agreement, and Consent for Treatment.

Please complete, sign, and date this form AFTER you have had a chance to review, understand, and/or ask questions about your rights to privacy and confidentiality, about physical therapy services, and about Mobile Physio's financial policy. You are only required to print off the first 2 pages of this packet and then give them to the therapist for your record, but please review the packet in its entirety.

Patient Full Name: ____ (please print)

DOB: ____ / ____ / ________ (mm/dd/year)

I hereby acknowledge that I have received and reviewed a copy of the Mobile Physio Notice of Privacy Practices, Financial Agreement, and Consent for Treatment (pages 3 through 11)

Patient Signature: ____

Date: ____

Please Check all that apply:

❏ I understand that in the state of Pennsylvania under laws related to practicing physical therapy without a physician referral, if my physical therapist is evaluating and treating me without a referral, after 30 days of treatment my therapist is obligated to obtain a referral from a licensed physician before continuing physical therapy services. I also understand that there may be other instances where my therapist must contact my physician, such as when symptoms are present for which physical therapy is a contraindication, cases where treatment is outside the scope of practice of physical therapy, and cases where treatment is beyond the education, expertise, or experience of the physical therapist. **I give consent for Mobile Physio to send documentation of my physical therapy evaluation and treatment sessions to my physician(s) when necessary.**

❏ I do *not* give consent for Mobile Physio to send information regarding my evaluation and treatment to my physician of record **or I do not have a physician of record**.

❏ If using Medicare insurance, I *do* give consent for Mobile Physio to use my personal information to file an insurance claim on my behalf for reimbursement.

❏ YES, I am interested in receiving occasional e-mails that may enhance my care through educational materials & videos, promotions, and wellness events related to Mobile Physio. We value your privacy and will NEVER sell your information to anyone else.

❏ NO, I am not interested or do not want to receive occasional e-mails that may enhance my care through educational materials & videos, promotions, and wellness events related to Mobile Physio.

❏ I consent to a Wellness Assessment, treatment, and exercise prescription for my functional limitations and to meet my Wellness goals as agreed upon by myself and Mobile Physio.

❏ I acknowledge waiver and release of Mobile Physio LLC in consideration of injury in participation of activities throughout our therapy and wellness plan of care.

❏ I understand that all relevant payments including deductibles, copays, coinsurance, and self-pay payments **will be made at the time services are rendered** and I agree to fulfill this request.

I agree to my above selections:

Patient Signature: ____

Date: ____

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.

I. Your protected health information (PHI).

Your “protected health information,” or “PHI” for short, includes information that can be used to identify you that we’ve created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We must notify you if there is a breach of your unsecured protected health information.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. You can request an updated copy of this notice from our office at any time.

II. How we may use and disclose your protected health information.

We may use basic information such as your name, email, or text/phone to communicate with you. We will not transmit medical information in electronic format unless encrypted and secure. However, you have the right to choose your preferred method of communication which may include text, email, or phone call.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we do not need your prior authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

We may use and disclose your PHI without your authorization for the following reasons:

1. **For treatment.** We may use and disclose your PHI to all health care personnel who provide you with health care services or are involved in your care.

2. **For payment.** To obtain payment for treatment, we may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process our health care claims. Information may be used per request from insurance company to file claims.

3. **For health care operations**. We may use and disclose your PHI in order to operate this medical practice. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement**. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; or when ordered in a judicial or administrative proceeding.

5. **For public health activities**. For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

6. **For health oversight activities**. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

7. **For research purposes**. In certain circumstances, we may provide PHI in order to conduct medical research.

8. **To avoid harm**. In order to avoid a serious threat to health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

9. **For specific government functions**. We may disclose the PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

10. **For workers' compensation purposes**. We may provide PHI in order to comply with workers' compensation laws.

11. **Appointment reminders and health-related benefits or services**. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

One use and disclosure requires you to have the opportunity to object:

1. **Disclosures to family, friends, or others**. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. If you are unable to agree or object to the disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.

All other uses and disclosures require your prior written authorization.

- Most uses and disclosures for marketing purposes require your authorization.
- Disclosures that constitute a sale of PHI require your authorization.
- In any other situation not described in this notice, we will ask for your written authorization before using or disclosing any of your PHI.
- If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

III. What rights you have regarding your PHI.

You have the following rights with respect to your PHI:

A. **The right to request limits on uses and disclosures of your PHI**. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it, except that we must agree if you ask us not to disclose PHI to your health plan for the purposes of payment or health care operations when the PHI is related to a health care item or service you have paid for out of pocket in full. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The right to choose how we send PHI to you**. You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, certified mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. **The right to see and get copies of your PHI**. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we

do, we will tell you, in writing or by phone, our reasons for the denial and explain your right to have the denial reviewed.

D. **The right to get a list of the disclosures we have made**. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or healthcare operations, directly to you, to your family, or in our facility directory. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or those made earlier than 6 years before your request.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last 2 years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge.

E. **The right to correct or update your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (1) correct and complete, (2) not created by us, (3) not allowed to be disclosed, or (4) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

IV. How to complain about our privacy practices.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with our office. You also may send a written complaint to the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

V. In case of Breach

In the case of an electronic breach, you will be notified by Mobile Physio as we become aware of the situation. If other providers were origins of breach (ie Square or Google) we will work with said company to inform you of any actions being or needed to be taken.

VI. Effective Date.

This Notice of Privacy Practices is effective as of 3-11-2024.

Financial Policy

Insurance:

Mobile Physio is currently contracted with Medicare and accepts most Medicare Advantage Plans as insurance providers for physical therapy services. Your insurance policy with Medicare or a Medicare Advantage Plan represents a formal agreement between them and you. To facilitate accurate billing to the insurance company, it's imperative that you provide us with up-to-date and valid insurance details. We undertake the task of submitting claims to Medicare/Medicare Advantage on your behalf. It's important to note that services covered under Medicare Advantage plans vary based on the plan. Should your plan deem a particular service as "not covered," you will bear full responsibility for the associated charges. It's crucial to understand that Mobile Physio does not assume responsibility for challenging decisions made by your insurance carrier regarding coverage.

For all other commercial and private insurances that Mobile Physio is not contracted with, we will supply you with the forms you will need to send to your insurance company for reimbursement. You will be required to pay our bill in full at the time you are seen.

Deductibles/Payments/Co-payments:

Our insurance contracts require us to collect any deductibles, coinsurance and copays, all of which will be collected at the time of the visit For your convenience we accept debit, credit, and HSA/FSA cards, as well as personal checks and cash. When you provide a check as payment, you authorize us to use information from your check to make a one-time electronic fund transfer from your account.

Consent to be Treated and Waiver of Responsibility

This agreement releases Mobile Physio LLC from all liability relating to injuries that may occur during mobile physical therapy and/or wellness activities. By signing this agreement, I agree to hold Mobile Physio LLC entirely free from any liability, including financial responsibility for injuries incurred, regardless of whether injuries are caused by negligence.

Explanation of Treatment:

My physical therapist from Mobile Physio LLC will explain the results of my physical therapy evaluation, the proposed physical therapy interventions within the plan of care, and the reasonable degree of progress that can be expected with my condition. I understand my therapist will explain any associated risks with the physical therapy treatment, as well as the risks of not proceeding with physical therapy and receiving no treatment. I also understand that there is no guarantee of progress with physical therapy services.

Acknowledgement of Risks:

I acknowledge the risks involved in physical therapy and wellness activities. These include but are not limited to exacerbation of symptoms, pain, stroke, seizure, and cardiac symptoms. I swear that I am participating voluntarily, and that all risks have been made clear to me. Additionally, I do not have any conditions that will increase my likelihood of experiencing injuries while engaging in this activity.

Safety and Communication:

I will make every effort to obey safety precautions as listed in writing and as explained to me verbally. I will ask for clarification when needed. I have not withheld any information that would benefit the physical therapist in creating a safer therapy program. I understand that I am encouraged to ask my physical therapist questions and express any concerns I have with the plan of care during the course of my treatment.

Right to Decline or Withdraw:

I reserve the right to decline any part of my proposed physical therapy plan of care, as well as reserve the right to withdraw from Mobile Physio's physical therapy services at any time.

Consent, Disclosure, and Privacy

Consent to Treatment:
I hereby give consent to the physical therapists at Mobile Physio LLC to provide physical therapy treatments to myself for conditions warranted by physical therapy treatment.

Assignment of Benefits:

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay. A photocopy of this assignment shall be considered as effective and valid as the original.

Insurance Responsibility:

I agree it is my responsibility to know and understand my insurance policy regarding referrals, physical therapy pre-certifications, deductibles, co-insurance, and co-payment, as it relates to out-of-network policy or Medicare. It is the policy of Mobile Physio to guide the client in obtaining out-of-network reimbursement from his/her insurance company; however, we cannot guarantee reimbursement after submitting. Mobile Physio is not obligated to withhold our statements or to wait until settlement has been made before receiving payment for our services.

Privacy Policy:

I have been provided an opportunity to review and have received a copy of Mobile Physio's privacy policies. All efforts to maintain your security and privacy have been made to the best of the ability at Mobile Physio.

Financial Responsibility:

Mobile Physio reserves the right to utilize the services of a collection agency in collecting delinquent accounts. If a collection service is utilized, I agree to pay all such costs incurred in collecting my account balance, including attorney’s fees. If my check is returned for insufficient funds, I agree to pay a returned check fee of $25 for each occurrence.