Policy Notice Sims Physical Therapy, Inc.

Regarding Insurance & Payment Policy

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, your insurance is a contract between you, your employer, and your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. It is our policy to call and verify benefits and eligibility in order for us to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed, at which time there may be a balance due on your account. In the event that this occurs we will mail you a statement and appreciate your prompt payment. We will accept the contracted rate and take the necessary adjustments if we are a participating provider with your insurance. Payment for service is due prior to each treatment visit. We accept cash, checks, and credit cards. Once your complete information is on file, we will be happy to submit your claims to your insurance company.

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Non-Covered Expenses

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment of charges denied due to an insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance company does not cover due to limitations of the policy or what they consider reasonable and necessary. It is your responsibility to know what your policy limits are. Our goal is to improve your condition successfully based on what the doctor and the physical therapist deem reasonable and necessary treatment, not on what your policy limits are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses.

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Consent and Acknowledgement of Receipt of Privacy Notice (HIPPA)

I understand that as part of the provision of healthcare services, Integra Physical Therapy creates and maintains health records and other information describing, among other things, my heath history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations (quality assessment and improvement activities, underwriting, premium rating, conduction or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent. This consent is given freely with understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for any reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations, be restricted. I also understand that the practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

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Consent to Treat, Assignment of Benefits and Release of Information

The undersigned consents to be (have minor) treated by Sims Physical Therapy, Inc. on an outpatient basis, which includes services rendered under the general and specific instructions of patient's physician surgeon. The undersigned hereby assigns to Sims Physical Therapy, Inc. all payments for services rendered to patient. The undersigned understands and accepts responsibility for any amount not covered by insurances, except in workers compensation claims. I hereby authorize Sims Physical Therapy, Inc. to furnish any and all information concerning my (minor's) treatment or illnesses to my (minor's) insurance carriers, attorney or other health professionals. I further authorize any holder of medical or other information about me (minor) pertaining to my (minor's) treatment or diagnosis to release it to Sims Physical Therapy Inc. **Initial___________**

Cancellation and No Show Fees

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore Sims Physical Therapy, Inc**. reserves the right to charge a fee of $25.00 for missed appointment's ("no shows")** and must be paid prior to your next appointment. If you have to cancel an appointment we ask that you please try to provide us with at least 24 hours' notice, you will not be charged if you reschedule your appointment within the same day, however, **we reserve the right to dismiss patients from our practice if you no show for an initial evaluation, after three no shows or cancellations without 24 hours' notice in 12 months, and at the therapist discretion after two no shows in a row .**

- **Running Late?** If you are running late, please call ahead and let us know. If you are running more than 10 minutes late, every attempt will be made to accommodate you, however, your treatment may need to be modified or rescheduled in consideration of other patients with already scheduled appointments.

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Patient Signature (Parent or Guardian Signature if Minor)	**Date**	**Printed Patient Name**
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Witness Signature	**Date**	

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you requested unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end if this Notice. If you request copies, we will charge you a $0.20 for each page and $35 per hour for staff time to locate and copy your health information as well as postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restriction on our use or disclosure of your health information. We are not required to agree to these additional restriction, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication : You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (**you must make a request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) we may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure or your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice.

Office Manager: Katie Anderson

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