TOTAL PHYSICAL THERAPY OF MASSAPEQUA
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED, AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Total Physical Therapy of Massapequa is required by law to protect the privacy of your professional health information, provide this notice about our information practices, and follow the information practices that is described here in.

USES AND DISCLOSERS OF HEALTH INFORMATION

Total Physical Therapy of Massapequa uses your health information primarily for treatment, conducting internal administrative activities and evaluating the quality of care we provide. For example, John Micena PT may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you.

Total Physical Therapy of Massapequa may also disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required to do so by law.

In any other situation, **Total Physical Therapy of Massapequa** may change its policy at any time. When changes are made, a new notice of Patient Information Practices will be provided to you upon your visit. You may also request an updated copy of our notice of Patient Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your record. You also have the right to request a list of instances when we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we do not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Total Physical Therapy of Massapequa** will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Total Physical Therapy of Massapequa** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on **Total Physical Therapy of Massapequa** health information practices or if you have a complaint, please contact the following person:

Steve Gazzo, PT
Total Physical Therapy of Massapequa
200 Boundary Avenue- Suite 205
North Massapequa, NY 11758
Tel: 516-586-4766 // Fax: 516-586-4758

I have read this Patient Information Practices Notice.

Patient Signature: _____ Parent/Guardian: _____ Date: _____

TOTAL PHYSICAL THERAPY OF MASSAPEQUA

PATIENT INFORMATION FORM

Please print and complete ALL items. If an item doesn't apply, put N/A

Date: _____

Patient Name: _____
last first middle

Address: _____
street city state zip

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

Sex: _____ Date of Birth: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____Phone: _____

***Referring Doctor:* _____*Phone:* _____ *Next Dr. appt.* _____**

Responsibility Information

PRIMARY Insurance Company: _____Phone #: _____

Policy Holder's Name:
_____
last first middle

ID/ MEMBER #:_____ Date of Birth: _____

Policy Holder's Employer: ___ _____

Employer's Address:_____ _____
street city state zip

SECONDARY Insurance Company:_____

Policy Holder's Name:
_____
last first middle

ID/ MEMBER #:_____ Date of Birth: _____

****

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ___ No ___ Date of Injury: _____

Company: _____ Address: _____

Phone Number: _____ Claim #: _____Contact Person: _____

****

IS THIS AN ACCIDENT CASE? Yes ___ No ___ VEHICLE ___ OTHER _____
Insurance Company to Bill: _____

Address:_____
street city state zip
Phone #: _____Claim #:_____

Adjuster Name: _____

****

Is there an attorney involved in your case? Yes _____ No ____

Attorney's Name: _____ Phone: _____

Address: _____
street city state zip

****

I hereby authorize Total Physical Therapy of Massapequa, Inc. to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize Total Physical Therapy of Massapequa to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

SIGNATURE: _____ DATE: _____

Signature for Minor (under 18 years of age)_____

RECEPTIONIST INITIALS _____

Dear Patient, there will be a change to our present insurance reimbursement policy as of June 1, 2018. The following will apply to all patients as it relates to their own personal insurance responsibilities. However, please be assured that we will continue to provide the best of patient care.

TOTAL PHYSICAL THERAPY OF MASSAPEQUA

OFFICE and PAYMENT POLICIES

Please read the following information regarding our office and payment policies.

- Copayments are due at the time of your visit.
- Co-insurance and/or deductibles will be billed monthly or at conclusion of treatment. We will accept cash, check or a credit/debit card.
- Your benefits are based on a contract between you, your insurance company, and your employer. Benefits vary and may change time from time and not all services may be covered. *You can contact your insurance company with any questions related to your coverage*.
- We cannot reduce or waive any copayments/co-insurance/deductibles. Your insurance company determines your copayment/co-insurance/deductible, not our office.
- All returned checks will be charged a $12 fee along with the amount that you originally owe.
- You are responsible to let our office know of any changes in address, phone numbers, and/or insurance information.
- A $25.00 fee will be due for missed appointments without prior notification.
- A fee of $.75 per copy will be charged to patient if any copies of medical records are needed.
- You are responsible for responding promptly to any requests from us or your insurance company to provide any additional information required from you. Any claims unpaid due to your failure to provide the information requested in a timely fashion will be your responsibility and must be paid in full.
- Any past due accounts will be turned over to a collection agency. Any collections fees, legal fees, or attorney's fees will be added to the amount that you owe.

If you should have any questions regarding the above information, please contact our office.

Print Name _____ Signature_____

Date _____

Dear Patient:

You may/will be receiving a check directly from your insurance company for services rendered at Total Physical Therapy of Massapequa.

DO NOT DEPOSIT OR CASH THIS CHECK.

When you receive the check from your insurance company, please sign the back of the check, endorse it to Total Physical Therapy of Massapequa and mail the check and **accompanying Explanation of Benefits** back to our office.

Thank you.

I acknowledge that this payment is for services rendered at Total Physical Therapy of Massapequa.

X

_____ _____

Patient's Signature Date

TOTAL PHYSICAL THERAPY OF MASSAPEQUA

PATIENT INFORMATION FORM

Please print and complete ALL items. If an item doesn't apply, put N/A

Date: _____

Patient Name: _____
last first middle

Address: _____
street city state zip

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

Sex: _____ Date of Birth: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____Phone: _____

***Referring Doctor:* _____*Phone:* _____ *Next Dr. appt.* _____**

Responsibility Information

PRIMARY Insurance Company: _____Phone #: _____

Policy Holder's Name:
_____
last first middle

ID/ MEMBER #:_____ Date of Birth: _____

Policy Holder's Employer: ___ _____

Employer's Address:_____ _____
street city state zip

SECONDARY Insurance Company:_____

Policy Holder's Name:
_____
last first middle

ID/ MEMBER #:_____ Date of Birth: _____

****

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ___ No ___ Date of Injury: _____

Company: _____ Address: _____

Phone Number: _____ Claim #: _____Contact Person: _____

****

IS THIS AN ACCIDENT CASE? Yes ___ No ___ VEHICLE ___ OTHER _____
Insurance Company to Bill: _____

Address:_____
street city state zip
Phone #: _____Claim #:_____

Adjuster Name: _____

****

Is there an attorney involved in your case? Yes _____ No ____

Attorney's Name: _____ Phone: _____

Address: _____
street city state zip

****

I hereby authorize Total Physical Therapy of Massapequa, Inc. to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize Total Physical Therapy of Massapequa to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

SIGNATURE: _____ DATE: _____

Signature for Minor (under 18 years of age)_____

RECEPTIONIST INITIALS _____