ATTAIN
PHYSICAL THERAPY

HIPPA NOTICE AND SUMMARY OF PRIVACY PRACTICE

ATTAIN PHYSICAL THERAPY, LLC inclusive of its affiliates and subsidiaries is required, by law, to maintain the privacy and confidentiality of your protected health information. Under the law, each patient has the following rights to the medical information we keep in our office:

1. You can ask to review your information at any time.
2. You can ask to limit who sees your information.
3. You can ask to see a list of where your information is sent.
4. You can ask to change your information if it is wrong.

We use this information for your treatment plan and for medical insurance payment only. A complete notice of privacy practices, with explanations of uses, disclosures, rights and information on how to file a privacy complaint is available at the following telephone number, (877) 696-6775, which is the office of the Secretary of Health and Human Resources.

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

For Treatment Purposes:

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. It is our policy to provide a substitute health care provider, authorized by Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situations.

For Payment Purposes:

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information at your expense.

For Workers' Compensation Purposes:

If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

For Emergency Purposes:

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

For Public Health Purposes:

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

For Judicial and Administrative Proceeding Purposes:

We may disclose your health information in the course of any administrative or judicial proceeding.

For Law Enforcement Purposes:

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

For Deceased Persons Purposes:

We may disclose your health information to coroners or medical examiners.

For Organ Donation & Research Purposes:

Though highly unlikely or probable we must inform you that there may a need to release your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

For Public Safety Purposes:

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a person or to the general public.

For Specialized Government Agency Purposes:

We may disclose your health information for military, national security, prisoner and government benefits purposes.

For Marketing & Other Communication Purposes:

We may contact you for marketing or fundraising purposes but will not disclose any health care information without your written consent. As a courtesy to our patients, it is our policy to contact you on the evening prior to your scheduled appointment to remind you of your appointment time. If you are unavailable, we leave a reminder message with an automated messaging system or individual answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment.

CHANGES TO THIS NOTICE AND SUMMARY OF PRIVACY PRACTICES

This office reserves the right to amend this Notice and Summary of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

DISCLOSURE OF INSURANCE PARTICIPATION, STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Health Plans Health Care Professional Participates With:

Medicare	Oxford		
Horizon	Qualcare		
Aetna	Tricare		
United Healthcare			
Cigna			

If the patient's health plan is not listed above, the provider and/or facilities providing services may not participate with the patient's health plan. The patient can inquire to determine if Attain Physical Therapy, LLC participates with the patient's healthcare plan. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

1. I understand that the health care professional that I am seeking healthcare services from is "in-network" with and does participate with my health insurance plan.

   Initials: _____

2. I understand that the amount or estimated amount the health care professional will bill the covered person for the services is available upon request.

   Initials: _____

3. I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided.

   Initials: _____

4. I understand that I may have a financial responsibility applicable to health care services provided by an in-network professional, in excess of my copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by their health benefits plan.

   Initials: _____

5. I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

   Initials: _____

The health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professional changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly.

PAYMENT POLICY

If you receive any payments from your insurance company for services rendered at our office, the payment must be brought into this office within one week of receipt and endorsed over to this office. If you fail to provide us with any and all payments made from your insurance company within 30 days of the check date you will be assessed a 5% late fee along with any potential legal fees.

In case of any action or proceedings to collect for unpaid services rendered or provided to you by Attain Physical Therapy, LLC, you agree that Attain Physical Therapy, LLC shall be entitled to recover all reasonable counsel fees and costs incurred by Attain Physical Therapy, LLC in the pursuit of any such action or proceeding.

Initials: _____

ACKNOWLEDGEMENT AND RECEIPT OF DISCLOSURES

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

COMPLAINTS

Complaints about your privacy rights, or how Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries has handled your health information should be directed to Management by calling this office at (855)-428-8246. If Management is not available by phone, you may make an appointment to discuss the matter in person.

If you are not satisfied with the way this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

YOUR HEALTH INFORMATION RIGHTS

- You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash, you may restrict that information to any insurer for purposes other than for treatment.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical equipment benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby appoint and authorize Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries, as my Designated Representative to:

- Release any information necessary to insurance carriers regarding my illness and treatments.
- Process insurance claims generated in the course of examination and/or treatment.
- Submit written appeals to my insurance carrier on my behalf and give permission for my insurance carrier to fully communicate with my Designated Representative, to obtain official information regarding any appeals performed, written and/or submitted, and/or act on all future matters related to the appeal process on my behalf.
- Allow a photocopy of my signature to be used to process insurance claims and will remain in effect until revoked by me in writing.

I have requested medical services from Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

TIMELINESS POLICY

We value your time and don't want to keep you waiting. Occasionally we are delayed by an unexpected event with another patient but be assured that the quality of your time will not suffer. If you arrive late, your treatment will end on its scheduled time in order not to keep the next person waiting.

NO SHOWS/CANCELLATIONS

It is important to keep any appointments you schedule or contact us if you require rescheduling or cancelling. This will allow our practice to schedule other patients who wish to be treated. Kindly give 24 hours' notice if you must cancel or reschedule your appointment. More than 1 cancellation or no show during your treatment may influence our ability to schedule future appointments. If you have a scheduled appointment and fail to contact our office to cancel or reschedule prior to your appointment time, a $100.00 charge will be assessed to your account, unless amended at the discretion of Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries. This charge will NOT be assessed to your insurance company and is YOUR responsibility.

Initials: _____

INFORMED CONSENT

I, the undersigned, acknowledge Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries, the inherent risks involved when using any type of fitness equipment at and in all other physical therapy or any other medical treatments relating therein. Accordingly, as consideration in exchange for being allowed to participate in any activities at Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries, I hereby agree to the following:

- I acknowledge that I am participating in physical therapy or any other medical treatments offered by Attain Physical Therapy LLC inclusive of its affiliates and subsidiaries during which I will receive instruction and information about health and fitness. I recognize that any of these treatments require physical exertion, which may be strenuous and may cause physical injury, permanent disability and even death, and I am fully aware of the risks and hazards involved.

- I understand that it is my responsibility to consult with a physician prior to and regarding my participation in any treatment programs. I represent and warrant that I am physically fit, and I have no medical condition which would prevent my full participation in a treatment program.

- In consideration of being permitted to participate in a treatment program, I agree to assume full responsibility for any risks, injuries, permanent disability, death, or damages, known or unknown, which I might incur as a result of participating in the program. If, however, I observe any unusual significant hazard during my participation, I will remove myself from participation and bring such hazard to the attention of management.

- In further consideration of being permitted to participate in a treatment program, I knowingly, voluntarily, and expressly waive any claim I may have against Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries its members, managers, affiliates, officers, directors, employees, agents or any therapist (collectively "Releasees"), for injury or damages that may sustain as a result of participating in the program. I also agree to indemnify Releasees from any and all third-party claims caused or resulting in whole or in part by my actions.

- I consent to emergency medical care and transportation in order to obtain treatment in the event of injury to me by Attain Physical Therapy, LLC inclusive of its affiliates and subsidiaries may deem appropriate. The releases contained herein extend to any liability arising out of or in any way connected with the medical treatment and transportation provided in the event of any emergency.

- I expressly agree that the terms of release and indemnity contained herein are intended to be as broad and inclusive as is permitted by the laws of the State of New Jersey. Any provision or portion of this Agreement of Release and Waiver of Liability found to be invalid by the courts having jurisdiction shall be invalid only with respect to such provision or portion hereof. The offending provision or portion shall be construed to the maximum extent possible to confer upon the parties the benefits intended thereby. Said provision or portion hereof, as well as the remaining provisions or portion hereof, shall be construed and enforced to the same effect as if such offending provision or portion thereof had not been contained herein.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above. I understand that by signing this Agreement I have given up substantial rights.

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____