Science Applied Artfully

Paradigm

Physical Therapy & Wellness

Please initial that you have read each section and sign at the bottom

____ **Cancellation/No-Show Policy:** *Paradigm Physical Therapy requires 24 hour notice for the cancellation of a scheduled appointment. A $50.00 charge will be applied for the cancellation or no-show of an initial evaluation. There is a $25.00 charge for the cancellation/no-show of any follow up visits without proper notice. This charge will not be covered by your insurance. We understand that extenuating circumstances may occur, therefore, we will allow for one cancellation before charging a fee.* **For every cancellation or no-show beyond one, a $25.00 fee will be assessed and may be automatically drafted from the credit card on file (if applicable).** *Maintaining regular treatment sessions is essential for positive outcomes. Repeated cancellations and/or no-shows will hinder your care and may result in discharge from our clinic.*

It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or later time. We will be happy to honor your request if other appointment times are available; however, simply arriving late or early changes the course of treatment for yourself and others. We cannot guarantee that we will be able to treat you if you are more than 10 minutes late for an appointment. Similarly, you may be asked to wait until your scheduled appointment time if you arrive early for your appointment. In order to provide you with the best possible care, we ask that you arrive at the time of your appointment.

We take these policies seriously because when a patient misses an appointment, three people are adversely affected:

1. *You, the patient – for not receiving the treatment you need.*
2. *Your therapist – as now he or she has a gap in the schedule.*
3. *Another patient – who could have had your appointment time.*

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having or not having pain are NOT reasons to cancel or no-show for your scheduled treatment. If you are in pain, it is important to come in, because there are treatments available and/or program modifications that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your course of treatment to correct the underlying causes of your injury which will prevent future setbacks.

____ **Scheduling Policy and Patient Consent:** *I do hereby give consent to Paradigm Physical Therapy & Wellness to perform Physical Therapy, to release any medical and billing information necessary to process insurance claims for my medical services, and I give permission to fax and release medical information to my referring Medical provider and any Medical provider involved in the care of my present condition. I also permit a copy of the authorization to be used in place of the original.* **Minor children under the age of 14 must be accompanied by a parent or guardian during their treatment time.** *In the case of Minor children 14 years or older that are dropped off or transport themselves, my*

parental signature below authorizes continued treatment and releases Paradigm of any liability for the transportation period to and from our clinic.

____ **Refund Policy**: *Due to the uncertainty of deductible, co-pay, and co-insurance amounts due at the time of service, Paradigm Physical Therapy may collect in error for these amounts. A reconciliation of your account will occur 30 days after treatment has ended and 30 days after all payments are received from insurances. A refund will be issued within 30 days of your account reconciliation. Special circumstances will be reviewed on a case by case basis.*

____ **Acknowledgement of Privacy Rights:** *My signature confirms I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand this information can and will be used to:*

- *Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-party payers for my health care services.*
- *Conduct normal health care operations such as quality assessment and improvement activities.*

Will there be anyone other than yourself that you would like to give permission to have and handle the following aspects of your care? □No □Yes, Name(s): _____
_____

- *Access to my financial information, in order to pay any deductible, co-insurance or copay payments or any other payments on my account.*
- *Ability to schedule, cancel and/or discharge therapy appointments.*
- *Ability to acquire information from the Physical Therapist or Physical Therapy Assistant regarding my treatment at Paradigm.*
- *Any other information specified by patient. Please list below:*
  _____
  _____

Emergency Contact: _____ *Ph#:*_____

I understand I must be notified in writing of any changes in disclosures or restrictions of information other than stated above.

I have read the above policies and do agree to the terms.

_____ _____

Patient/Guardian Signature **Date**

Past medical history (check all that apply):

- ☐ *Heart Disease*
- ☐ *Heart Attack*
- ☐ *Heart Surgery*
- ☐ *Angina*
- ☐ *COPD*
- ☐ *CVA/Stroke*
- ☐ *TIA*
- ☐ *High Blood Pressure*
- ☐ *Asthma or Pulmonary Disease*
- ☐ *Diabetes*
- ☐ *Ulcer or Stomach Disease*
- ☐ *Bowel Disease*
- ☐ *Kidney Disease*
- ☐ *Liver Disease*
- ☐ *Anemia or other blood disease*
- ☐ *Overweight*
- ☐ *Cancer*
- ☐ *Depression*
- ☐ *Osteoarthritis*
- ☐ *Rheumatoid Arthritis*
- ☐ *Osteoporosis/Penia*
- ☐ *Back Pain*
- ☐ *Lyme Disease*
- ☐ *Bronchitis*
- ☐ *Seizures*
- ☐ *Allergies*
- ☐ *Headaches*
- ☐ *Rheumatic Fever*
- ☐ *Sexually Transmitted Disease*
- ☐ *Alcoholism*
- ☐ *Hearing, vision, speech, and/or communication problems*
- ☐ *Surgery:*_____ _____ _____ _____ _____ _____ _____

Are your symptoms:

- ☐ *Getting worse*
- ☐ *The same*
- ☐ *Improved*

Are you currently?

- ☐ *Pregnant (female patients only)*
- ☐ *Under stress*
- ☐ *Depressed*

Date of last physical exam:

_____

In general, how would you say your health is?

- ☐ *Excellent*
- ☐ *Very good*
- ☐ *Good*
- ☐ *Fair*
- ☐ *Poor*

Do you work out?

- ☐ *Not at all*
- ☐ *Light: 1-2 times/week*
- ☐ *Moderate: 3-4 times/week*
- ☐ *Heavy: 4-6 times/week*

In the past 3 months have you had?

- ☐ *A change in your health*
- ☐ *Nausea or vomiting*
- ☐ *Fever, chills, or sweats*
- ☐ *Unexplained weight changes*
- ☐ *Numbness or tingling*
- ☐ *Changes in appetite*
- ☐ *Difficulty swallowing*
- ☐ *Changes in bowel/bladder function*
- ☐ *Urinary tract infection*
- ☐ *Shortness of breath*
- ☐ *Dizziness*
- ☐ *Upper respiratory infections*

Have you fallen in the past 12 months?
□*Yes* □*No* **# of falls_____**

Do you or have you ever smoked or chewed tobacco? □*Yes* □*No*

Do you drink alcohol? □*Yes* □*No*
If yes, how many drinks do you have on average per week?

_____

Do you have any health conditions that are not listed? If yes, please explain. □*Yes* □*No*
_____+
_____
_____
_____

Highest level of education completed…
- □ *Less than high school*
- □ *Graduated from high school*
- □ *Graduated from college*
- □ *Postgraduate school or degree*

List all medications currently taking:

_____
_____
_____
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Dosage:

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Notice of Protected Health Information Practices (Privacy Policy)

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.

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Paradgim Physical Therapy and Wellness is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies ad procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

    a. **Treatment**. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.

    b. **Payment**. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

    c. **Health Care Operations**. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. **Uses and Disclosures With Patient Authorization**. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object**. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

    a. **Uses and Disclosures Required by Law**. We will disclose your health information when required to do so by law.

    b. **Public Health Activities**. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

    c. **Abuse and Neglect**. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

    d. **Regulatory Agencies**. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

    e. **Judicial and Administrative Proceedings**. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

    f. **Law Enforcement Purposes**. We may disclose your health information to law enforcement officials when required to do so by law.

    g. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

    h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

    i. **Threats to Health and Safety**. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

    j. **Military/Veterans**. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. **Workers' Compensation**. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. **Marketing**. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.

m. **Appointment Reminders**. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. **Other Uses and Disclosures**. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. **Uses and Disclosures to Business Associates**. With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information**. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.

2. **Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. **Right to Verbally Object**. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. **Right to Seek an Amendment of Your Health Information**. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. **Right to an Accounting of Disclosure of Your Health information**. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. **Right to Confidential Communications**. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. **When Authorizations are Required**. An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.

8. **Right to Revoke Your Authorization**. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

9. **Right to Opt-Out of Fundraising Communications**. We may contact you for fundraising purposes or have someone contact you on our behalf. However, you have a right to opt out of fundraising communications. You can do so in writing by calling the Compliance Officer at 505-866-0055 or sending an email to www.paradigmnm.com with your instructions to opt out of fundraising communications.

10. **Right to be Notified Following a Breach of Your Information.** If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.

11. **Right to Receive Copy of this Notice**. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at 505-866-0055. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact our Compliance Officer at 505-866-0055. All complaints must be submitted to the Practice in writing at 535 HWY 314 S.W. Los Lunas, N.M. 87031 . There will be no retaliation for filing a complaint.

Effective Date

The effective date of this Notice is 1/1/2019 .

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Paradigm Physical Therapy and Wellness for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 535 HWY 314 S.W. Los Lunas, N.M. 87031, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____
   _____
   _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____Other (explain) _____

_____ _____
Signature of Authorized Practice Representative Date