NOTICE OF PRIVACY PRACTICES

Regen Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein. This notice describes how medical information about you may be used or disclosed and how you can obtain access to information.
Please review it carefully.

USES AND DISCLOSURES OF HEALTH INFORMATION

Regen Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Regen Physical Therapy 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. Regen Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law. In any other situation, Regen Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. Regen Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of 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 records. You also have the right to request a list of instances where 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 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. Regen Physical Therapy will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Regen Physical Therapy 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 HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Regen Physical Therapy's health information practices, or if you have a complaint, please contact the following office:

REGEN
PHYSICAL THERAPY, LLP

Privacy Officer: Regen Physical Therapy LLP
Mailing Address: 450 Mamaroneck Ave, Suite 411, Harrison, NY 10528
Telephone: 914-732-3160 Fax: 914-732-3112
Email:Seth@Regenpt.com Website: RegenPT.com

We ask you to sign this acceptance/acknowledgement of our HIPAA Notice of Privacy Practices. We also ask you to sign an Authorization for Release of Information form to assure you that we do indeed live up to our policies. You can request a copy of this form anytime.

Patient Signature: _____ Date: _____

Patient Authorization Record for Regen Physical Therapy, LLP

Authorization for treatment: I hereby give authorization for the performance of such rehabilitation procedures as permitted by NY Statues under the appropriate scope of practice, in the judgment of physical therapist, deemed necessary.

Authorization for Release of Information: I agree that Regen Physical Therapy may provide information from my medical record to persons involved in my medical care. I authorize release of medical information necessary to obtain payment for Regen Physical Therapy of any benefits available for services rendered. I agree that Regen Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. I authorize release to third parties (including the social security administration or its fiscal intermediaries, when applicable) any medical or other information necessary to determine insurance benefits and process claims.

Authorization for Release of Payment: I request payment of authorized insurance and/or government benefits (Medicare, Medicaid, etc.) be made directly to Regen Physical Therapy.

Patient Agreement: I agree to pay Regen Physical Therapy charges for services rendered to me during my course of treatment (i.e. copayments, coinsurance, and deductible). I agree to pay those charges which may not be paid by my health insurance and are my responsibility. If I do not adhere to this agreement, I agree to pay Regen Physical Therapy collection costs including attorney and court fees. I also accept responsibility for fees that exceed the payment made by my insurance, if Regen Physical Therapy does not participate with my insurance (self-pay).

Adherence to No Show Policy: Effective January 1, 2015, patients who fail to present for a scheduled appointment, without contacting the practice at least the day prior to their appointment, will be considered a "no show" and will be charged a fee of **$35.00** on their second missed appointment. This fee will be charged directly to the patient and must be paid at the time of the next visit. I agree to pay this fee if applicable. Policy does not apply for emergencies, such as a car accident before scheduled appointment.

I understand that while this consent is voluntary, if I refuse to sign this consent, Regen Physical Therapy can refuse to treat me. I understand this authorization can only be revoked in writing, and if I revoke my consent, such revocation will not affect any action that Regen Physical Therapy took before receiving my revocation.

Printed Patient Name: _____ Date: _____

Patient or Parent/Guardian Signature: _____

PLEASE SIGN NEXT PAGE →