

**VIRTUS PHYSICAL THERAPY HIPAA FORM**

*This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

**Introduction**

At Virtus Physical Therapy, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective immediately and applies to all protected health information as defined by federal regulation.

**Uses and Disclosures**

The following are examples of ways we use your health information.

1. We use your health information to document and plan treatment, progress, planning, etc.

2. We use your health information for payment. For instance, we need to send health information including procedures done and diagnoses to your insurance company.

3. We use your health information for regular health operations. For example, our compliance officer regularly chooses medical records for audits. This practice ensures that we are constantly working towards improved quality and effectiveness.

4. There are services provided in our organization through contacts with business associates. Examples include orthotic/prosthetic fabrication, billing and transcription services.

5. We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location, and general condition.

The following are examples of other purposes for which Virtus Physical Therapy is permitted or required to disclose confidential information without the individual’s written authorization.

1. Uses and disclosures for public health activities;

2. Reporting victims of abuse, neglect, or domestic violence;

3. Disclosures for judicial and administrative proceedings;

4. Disclosures for law enforcement purposes;

5. Disclosures to avert a serious threat to health or safety; and

6. Uses and disclosures for specialized government functions.

*Separate Statements for Certain Uses or Disclosures*

Virtus Physical Therapy may contact patients with appointment reminders, requests for the patient to contact Virtus Physical Therapy for appointments, notices and letters concerning medical findings. Virtus Physical Therapy may also contact the patient about treatment alternatives or other health related benefits and services that may be of interest to the individual.

**Individual Rights**

Although your health record is the physical property of Virtus Physical Therapy, the information belongs to you. You have:

1. The right to request restrictions on certain uses and disclosures of your information;

2. The right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.

3. The right to receive confidential communications;

4. The right to obtain a copy or inspect your health information;

5. The right to amend protected health information;

6. The right to receive an accounting of disclosures of protected health information.

**Virtus Physical Therapy’s Rights**

1. Virtus Physical Therapy has 30 days with which to comply with a patient’s request to review or copy their health information. Virtus Physical Therapy may charge a fee for copying the health record.

**Virtus Physical Therapy’s Duties**

1. Virtus Physical Therapy is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information;

2. Virtus Physical Therapy is required to abide by the terms of this Notice; and

3. Virtus Physical Therapy reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all confidential information that it maintains. Revisions to this Notice will be posted.

**Complaints**

Individuals may complain to Virtus Physical Therapy’s Administrator in writing. Please mail complaints to 952 Golf House Rd W Ste 1, PMB 206. You may also contact the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave., S.W., Rm. 509F, HHH Building, Washington DC 20201.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Personal Information

I give my permission to Virtus Physical Therapy to release information, verbal and written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, school, related health-care provider, or other assignees as it relates to my treatment. I further authorize Virtus Physical Therapy to obtain medical records from my physician or other medical professionals as it relates to my treatment. \_\_\_\_\_\_\_\_\_ INITIALS

I give permission to Virtus Physical Therapy to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials: \_\_\_\_\_\_\_

Methods of Contact (Please check all that apply)

**Home Telephone**

OK to leave message with detailed information

Leave message with call-back number only

OK to leave message with family members or other persons living in the same household

**Work Telephone**

OK to leave message with detailed information

Leave message with call-back number only

OK to leave message with secretary, assistant, or other individual who regularly answers the phone

**Cell Telephone**

OK to leave message with detailed information

Leave message with call-back number only

**Email** (Please specify email address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to leave email with detailed information (for appointment reminders)

I would not like to be contacted via email

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_