NEW AGE PHYSICAL THERAPY P.C.
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HIPPA PRIVACY NOTICE

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

INTRODUCTION

New Age Physical Therapy, P.C. understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information". Protected health information includes any individually identifiable information that we obtain from you or others that relate to your past, present or future physical or mental health, the health care you have received or payment of your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the office manager.

PERMITTED USES AND DISCLOSURE

We can disclose your protected health information for purposes of treatment, payment and health care options. For each of those categories of uses and disclosures, we have provided a description and example below. However, not every particular use or disclosure in every category will be listed.

Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken ankle may need to know if you have diabetes, because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regiment appropriate to your care.

Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payer about your medical condition to determine where the proposed course of treatment will be covered. When we subsequently bill the Third Party Payer for the services rendered to you, we can provide the Third Party Payer with information regarding your care if necessary to obtain payment. Federal and State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.

Health Care Operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are needed and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the derided and enucleated-identified information to study health care and health care delivery without learning who you are.

ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided a copy of the privacy notice from New Age Physical Therapy, P.C. I, further give my doctor permission to discuss my medical history and/or treatment with me while any family members, friend or person is present with me in the room during my office visit.

Date _____ Signature _____.

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