

**GRAYSLAKE REHABILITATION
AND COMPLETE PHYSICAL THERAPY, LLC**
NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS NOTICE CAREFULLY

Grayslake Rehabilitation and Complete Physical Therapy, LLC knows that medical information about your health is personal. We protect your medical information. We prepare a record of your therapy and services for quality care.

We have the right to change our practices and make new provisions for the protected health information we maintain.

For additional information regarding matters covered by this notice, please contact Bonnie Richtman, or Primary Contract, at (847)223-8001. All written requests should be delivered to Bonnie at Grayslake Rehabilitation and Complete Physical Therapy, LLC.

The following describes different ways that we use and disclose medical information: (Not every use of disclosure will be listed.)

FOR TREATMENT: We may provide medical information about you to doctors, physical therapists, medical secretaries, nurses, technicians or others who provide services that are part of your care.

FOR PAYMENT: We may provide medical information about you to allow the billing and payment of your treatment and services.

APPOINTMENT REMINDERS: We may use medical information to contact you regarding your medical appointments. A message may be left regarding your appointment at your home or work.

HEALTH-RELATED BENEFITS AND SERVICES: We may use medical information about you to tell you about health-related benefits or services that might be of interest to you.

INDIVIDUALS INVOLVED IN YOUR CARE OR IN THE PAYMENT OF YOUR CARE: We may release medical information about you to a friend or family member who is involved in your medical care with consent.

AS REQUIRED BY LAW OR PUBLIC HEALTH OR RESEARCH TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY OR FOR SPECIALIZED GOVERNMENT FUNCTIONS OR FOR WORKER'S COMPENSATION: We may disclose medical information, if required to do so.

You have the following rights regarding the medical information we keep for you:

TO REQUEST RESTRICTIONS, TO ASK FOR CONFIDENTIAL COMMUNICATIONS TO INSPECT AND COPY: You may obtain a paper copy of this notice of privacy policies upon request. You may inspect and obtain a copy of your health record as provided by 45 CFR 164.524 , reasonable copy fees apply in accordance with state law. You may obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528. You may request confidential communications of your health information as provided by 46 CFR 164.5322(b). You may request a restriction of certain uses and disclosures of your information as provided by 45 CFR 164.522(a) (however, we are not required by law to agree to a requested restriction).

RIGHT TO AMEND: You may amend your health record as provided by 45 CFR 164.526.

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Contact, Bonnie Richtman, as mentioned above or with The Office for Civil Rights, U.S. Secretary of the Department of Health and Human Services.

All requests, complaints, etc., should be submitted in writing.

My signature indicates that I have read and understand the above privacy practices.

Signature of Patient or Guardian (if minor)

Date

PATIENT NAME (PRINTED) _____

**GRAYSLAKE REHABILITATION
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PATIENT RECORD OF DISCLOSURE

DATE: _____ Initials: _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

If information and/or billing should be sent to a **destination other than the home**, please indicate below:

If you would like information to be made **available on your behalf to a family member or a friend**, please indicate name and address below:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES OF HEALTH INFORMATION MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION			
Date	Disclosed to	Purpose of Disclosure	By Whom
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**GRAYSLAKE REHABILITATION
AND COMPLETE PHYSICAL THERAPY, LLC**

MEDICAL HISTORY

Name: _____ Age: _____

Occupation: _____ Date of Injury: _____

Why were you referred to physical therapy? _____

Please describe how your injury occurred: _____

Have you previously been treated for this condition? Yes____ No_____

If yes, what treatment did you receive? _____
Where? _____

Have you received any special exams/tests related to this injury? Yes____ No_____

Please list: _____

Do you have a history of: (Check all that apply)

- | | | |
|----------------------------|----------------|------------------|
| ____ Heart Condition | ____ Diabetes | ____ Seizures |
| ____ High Blood Pressure | ____ Stroke | ____ Cancer |
| ____ Respiratory Disorders | ____ Dizziness | ____ Other _____ |

In the last five years have you been admitted to a hospital or have you undergone any surgical procedures? ____ Yes ____ No

If yes, what was the condition/treatment? _____

Please list all medications you are currently taking:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

What type of physical activities do you participate in? _____

At the present time, what are the most difficult tasks for you to perform? _____

Are you now, or is there a chance that you may be pregnant? Yes _____ No_____

PATIENT'S SIGNATURE _____ **DATE** _____

THERAPIST'S SIGNATURE _____ **DATE** _____

**GRAYSLAKE REHABILITATION
AND COMPLETE PHYSICAL THERAPY, LLC
OFFICE POLICIES FORM**

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress. **POOR ATTENDANCE MAY ADVERSELY AFFECT MY DISABILITY STATUS, AND/OR MY INSURANCE COMPANY MAY CHOOSE NOT TO MAKE PAYMENTS.**

APPOINTMENTS:

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater than 5 minutes may result in a shortened treatment or cancellation. We require advance notice of 24 hours for cancellation.

NO SHOW/LATE CANCELLATIONS:

PLEASE NOTIFY US NO LATER THAN 24 HOURS PRIOR TO YOUR APPOINTMENT IF YOU NEED TO CANCEL OR RESCHEDULE OR YOU WILL BE CHARGED A \$25.00 FEE. THIS CHARGE WILL NOT BE COVERED BY INSURANCE. If your physician orders you to discontinue therapy, you **MUST** call to cancel your remaining appointments.

_____ Initials

RESPONSIBILITIES:

IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR COVERAGE FOR OUTPATIENT PHYSICAL THERAPY. You need to verify your percentage of payment per visit, any copayments, deductibles and limits per calendar year. We at Grayslake Rehabilitation will be glad to bill your insurance as a courtesy to you, **BUT IT IS YOUR RESPONSIBILITY TO COVER ANY PORTION NOT PAID BY INSURANCE.** If you need any assistance in this matter, please feel free to contact our business office.

_____ Initials

HOME EXERCISE PROGRAM:

Photos may be taken to help clarify proper form for your home exercise program. These are provided as a courtesy to you and they are for your use only. Grayslake Rehabilitation will keep them as part of your medical file and are, therefore, protected by your HIPPA rights.

FINANCIAL POLICY:

I authorize my insurance company to pay benefits directly to Grayslake Rehabilitation & Complete Physical Therapy, LLC. I am financially responsible for any unpaid balance on my account. **ALL COINSURANCE, COPAYMENTS AND DEDUCTIBLES ARE DUE AS SERVICES ARE RENDERED.** We submit all billing to insurance companies as a courtesy to our patients, however, we will collect the deductibles and copayments at the time of visit.

_____ Initials

COLLECTION AGREEMENT:

I hereby acknowledge and understand that I am financially responsible for any unpaid balances on my account. Unless I make prior arrangements, I will pay "out-of-pocket" charges at the time of service. If I default and do not pay, Grayslake Rehabilitation and Complete Physical Therapy, LLC is entitled to the right of recovery of all collections expenses up to 35%, including all court costs and reasonable attorneys' fees incurred for the purpose of securing payment if I am named the insured. I agree that any credit balance on an account of any family member may be applied to the account of anyone else in my family. If insurance denies payment for any reason, I will still pay my co-pay or co-insurance portion.

I have read and understand the above stipulations and agree to comply with these policies. I hereby give Grayslake Rehabilitation permission to perform physical therapy as prescribed by my physician on myself or my child (if applicable).

Signature of Patient or Guardian (if minor)

Date