HIPAA COMPLIANCE

We are required by law to maintain the privacy of Protected Health Information and to give you this notice describing our privacy practices. This explains your rights and our legal obligations regarding your PHI. PHI identifies you individually and is created through your treatment within our practice or what we receive from you or another healthcare provider, health plan, employer, or healthcare clearing house that relates to your physical or mental health, the provision of health care to you or the payment for your personal healthcare.

To Provide Treatment: We will use your information within our practice to provide you the best physical therapy care possible. This may include clinical and administrative procedures we utilize to coordinate scheduling and care between clinical staff and administrative staff. We may share your PHI with other health care providers, referring therapists & diagnostic laboratories.

To Obtain Payment: We may use your health information to bill and collect payments from you, a health plan or third party. This could include insurance claims filed for you in the mail or sent electronically. This may include activity with your insurance plan to make determination of eligibility, coverage and/or medically necessary review.

To Conduct Health Care Operations: Your PHI may be used during evaluations by our staff. This includes in training programs for students, interns, clinical and business employees and associates. It is possible that your information might need to be disclosed during audits by insurance companies or government agencies as part of their quality assurance and compliance reviews. Your information may be reviewed during the routine process of certification, licensing or credentialing activities.

For Patients Reminders: We may at time need to remind you of a scheduled appointment or it is time to schedule additional appointments. We do this because we believe your care is important to your progression in your rehabilitation process. We believe these communications are an important part of our philosophy of creating a partnership with our patients to be sure they receive the best physical therapy care possible.

Abuse or Neglect: We will notify government authorities if we believe the patient is a victim of abuse, neglect or domestic violence. We will only do this when we are compelled by our ethical judgment and we believe that we are required or authorized by law or the patients' agreement.

Law Enforcement: As required or permitted by federal and state law, we may disclose your health information to a law enforcement official for law enforcement purposes.

Public Health and National Security: We may be required to disclose to federal officials or military authority PHI necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that public safety could benefit and lead to the control or prevention of an epidemic or the understanding or new side effects of a drug or medical device.

Minors: We may disclose to parents or guardians the PHI of a minor child unless disclosure is otherwise prohibited by law.

Family, Caregivers, and Friends: We will only share your PHI with those you tell us will be helping with your home care, treatment, medication or payment. We will ask your permission first, however in case of an emergency (when you are unable) we will use our professional and best judgment when it involves participation in your care.

Business Associate: We may disclose your health information to BA who performs functions on our behalf including but not limited to services such as billing, filing and medical claims. All of our BA are obligated by law to protect the privacy and security of your PHI.

PATIENT RIGHTS: You have the right to restrict certain uses and disclosures of your PHI. We will make every effort to honor reasonable restrictions from patients. Request should be made in writing. You have the right to request that we communicate to you only in certain ways. You may request that we communicate your information privately with no other family members present or through mailed communication that are sealed or that we may leave messages only at specified phone numbers. You have the right to read, review and copy your health information, including your complete chart and billing records. If you would like a copy of your health information, please let us know. We have up to 30 days to make this information available and may charge a reasonable fee to duplicate, assemble and deliver your copy. You also have the right to ask us to update or modify your records if you believe your records are incorrect or incomplete. We will be happy to accommodate as long as our office maintains this information in order to standardize our process. In writing please request and describe your reason for the change. Your request may be denied if the health information requested was not created by our office, is not part of our records, or if the record is determined to be inaccurate. You have the right to ask us for a description of how and where your health information was used by our office for any reason other than treatment, payment or health operations. Our documentation procedures enable us to provide information on health and billing information from June 2010 on forward. Please request in writing the time period for which you are interested. Please limit this request to not more than 6 years at a time. You may request a paper copy of this notice at any time. You have the right to express complaints to us or to the Secretary of Health and Human services if you believe your rights have been compromised*. All complaints must be made in writing and submitted within 180 days of when you suspected the violation. There will be no retaliation against you for filing a complaint. A complaint can first be made to our HIPAA compliance officer at the practice address of 163 Pottstown Pike, Chester Springs PA 19425.*

Patient Name _____ **Date** _____

Patient Signature _____

Guardian Signature _____

I, _____ give permission for Kinetic Physical Therapy to share my PHI with the following individuals:

_____, _____

(Name) (Relationship to patient)