

Welcome to Shine Integrative Physical Therapy

Client waiver

ACKNOWLEDGEMENT OF HEALTH INFORMATION PRIVACY ACT

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

Each time you visit a healthcare provider, a record of your visit (containing your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatments) is made. This Information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of Information for public health officials
- An outcomes tool with which we can improve the care we deliver

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where, and why others may access your health information.

Understanding Your Health Information Rights

Although your' health record is the physical property of the healthcare provider. The information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45CFR164.522)
- Obtain a paper copy of the notice of Information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health Information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health Information except to the extent that action has already been taken.

We are required to:

- Maintain privacy of your health Information and abide by the terms of this notice
- Provide you with a notice as to our legal duties & privacy practices with respect to your information.
- Notify you if unable to fulfill a requested restriction on disclosure or amendment to record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations.

We reserve the right to change our practices and to make the changes effective for all protected health Information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment. If you have questions and would like additional information, you may contact our clinic. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. We will not retaliate if you file a complaint.

I understand that the Shine Integrative Physical Therapy LLC will use and disclose health information about me in the course of providing care to me. I understand that my health information may include information both created and received by the clinic, may be in the form

of written or electronic records or spoken words, and my include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

By signing below, I agree that I have reviewed this privacy practice and agree to these conditions. I will be offered a copy of this form and may request a copy at any time.

Signature _____ **Date** _____

RELEASE OF INFORMATION

In order to provide the best care possible, we may need to discuss your case with other health care professionals and health care facilities. I authorize Shine to release my medical records to my physician and other health care professionals. I also authorize Shine to request pertinent medical records from these professionals. Please list pertinent professionals and their contact information:

Signature _____ **Date** _____

PATIENT MISSED APPOINTMENT POLICY

We are committed to assisting you with your health concern(s). We expect you to attend all of your appointments (emergency situations not withstanding). If you need to reschedule your appointment, we require 24 hour notice. **Failure to cancel your appointment within 24 hours will result in a \$30 fee. Insurance will not cover this fee.** This fee will be due prior to your next appointment in order to obtain treatment. In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. By signing below, you agree to this policy.

Signature _____ **Date** _____