JOINT MOVEMENTS
PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES

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

The Healthcare Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal program, which requires that all medical records and other individually identifiable health information used or disclosed by us in any form (electronicaaly, on paper, or orally) is kept properly confidential. This act gives you the patient, rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose your health information. A copy of the new privacy practices will be available upon request.

Uses and Disclosures: By law your medical information may be used and disclosed, without your authorization, *solely* for the purposes of treatment, payment and healthcare operations or when required by law. For example:

Treatment: We may use and disclose all or a portion of your health information to the staff of Joint Movements Physical Therapy, with your physician or other healthcare provider, for the purpose of providing and coordinating your care.

Payment: We may use and disclose your health information to your insurance company or companies for the purpose of obtaining payment of services or to determine coverage. This includes automobile insurers and workers' compensation insurers.

Healthcare Operations: We may use and disclose your information during routine operations of practice such as quality assessment, education and training, accreditation, certification, licensing or credentialing activities.

Required by Law: We may use and disclose your health information to state and federal agencies when required to so by law. This includes public health concerns and issues of national security.

Authorization: Disclosure of your health information for any other purposes will require your individual written authorization. Once given, you have the right to withdraw the authorization at any time, in writing. Your revocation will not affect any disclosures made when the authorization was in effect.

Patients' Rights: You have certain rights under the federal privacy standards.

Confidentiality: You have the right to receive confidential communication concerning your medical condition and treatment.

Inspect and Copy: You have the right to inspect and receive a copy of your protected medical information. You will need to pay for copies of any records that we provide. As permitted by federal regulations, we require that all requests be submitted in writing.

Amend: You have the right to amend and submit corrections to your protected health information.

Accounting: You have the right to receive an accounting of how and to whom your protected health information has been disclosed for reasons other than treatment, payment and routine operations of practice or as required by law.

Restrictions: You have the right to request restrictions on the use and disclosure of your health information. We are not required to agree to these additional restrictions.

Complaints: You have the right to submit a complaint about our privacy practices. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address above. You will not be penalized for filing a complaint.

For more information regarding this notice please contact Joint Movements Physical Therapy.

Acknowledgement of Receipt of Notice of Privacy Practices

I _____ have read and received a copy of privacy practices from Joint Movements Physical Therapy.

Communication of Patient Information

Do allow us to inform others regarding your care and treatment? If so, please indicate who:_____

Do you allow us to leave information on you answering machine or voicemail service? **YES** **NO**

Signature:_____ Date:_____

I have attempted to obtain patient's signature in Acknowledgement of Privacy Practices, but was unable to do so as indicated

Reason:_____ Initials _____ Date:_____