Manual Orthopedic Physical Therapy, Inc.

885 Canarios Court, Ste. 110
Chula Vista, CA 91910
(619) 656-5102 (619) 656-5103 facs.

955 Lane Avenue, Ste. 201
Chula Vista, CA 91914
(619) 421-9521 (619) 421-9568 facs.

Acknowledgement of Receipt of Notices

I hereby acknowledge that I signed and/or received copies of this office's notices pertaining to but not limited to:

1. HIPAA Privacy Notice
2. HIPAA Information and Consent Form
3. Patient's Rights and Responsibilities
4. Manual Orthopedic Physical Therapy, Inc. Finance Policy
5. Insurance Plan Description (if applicable)

I further acknowledge that I will receive any amended copies of the above notices.

_____ _____
Patient Signature Date

_____
Printed Name

If not by signed by the patient, please indicate relationship:_____

Name of Patient:_____

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FINANCE POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy.

It is important that you understand that:

1. Your insurance is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they limit or do not cover.

Payment for services, which may include deductible, coinsurance, or copay, is due at the time services are rendered unless payment agreement exists with your insurance carrier or personal arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa and Discover. Your appointment will be rescheduled if payment is not made at the time of service.

Please note we do not accept third party liens or coordinate payments with third party payers or attorneys. If you elect to use your health insurance for personal or automobile inflicted injuries you will be doing so at your own financial risk and responsibility. ***Any services rendered will be EXCLUDED from any existing claim or case.*** As stated above, applicable copayment amounts and or deductibles will be due at the time of service.

Any non-covered services will be patient responsibility and full payment will be due within 15 days from the date of the denial.

Please be advised there will be a $25.00 service fee added to your account for returned checks. Patients should keep their accounts current while waiting for the insurance company payment. Should the account be referred for collections, the undersigned shall pay reasonable collection expenses including attorney's fees.

If you are unable to keep your appointment, please call in advance so that someone else may see the therapist in the time which has been reserved for you. There will be a **$50.00** charge added to your account for each no show appointment and for less than 24 hour cancellation notice. After three (3) no shows or cancelled visits, you will be automatically discharged and the referring physician and or claims adjuster will be notified.

As physical therapy providers, our relationship is with you. We understand that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department **(619 656-5102)** for assistance in the management of your account.

If you have any questions regarding the above information or regarding insurance coverage, please do not hesitate to ask us. We are here to help.

The undersigned certifies that he/she has been informed and has read the foregoing and is the patient, patients' parents or guardian, or is duly authorized by that patient as patient's general agent, and that he/she understands the terms contained in this finance policy.

_____ _____

Signature Date

_____

Relationship to patient

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patent. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services: www. hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matter related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments, call with insurance benefit information or make collection inquiries. We may do this by telephone, e-mail, U.S. mail or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the provider.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services without your written consent.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you:

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (full Notice is available upon request)

Changes to this Notice:

We reserve the right to change this Notice. We will post a copy of the current Notice in our facility with the current effective date on the first page.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint. Or you may file a complaint with the CA Department of Healthcare Services: HIPAATeam@dhcs.ca.gov 916-552-9444 P.O. Box 997413, MS 4721 Sacramento, CA 95899-7413.

Acknowledgement of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records. This acknowledgment provides that you have declined to accept the Complete Notice and instead requested this Short Form. We post a copy of the Current Complete Notice of Privacy Practices in our facility and you may also ask for a copy.

December 20, 2005

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NAME:_____AGE:_____

*Please give explanation in space provided on **ALL YES** answers.*

Height (feet, inches) _____Weight (pounds) _____Occupation _____

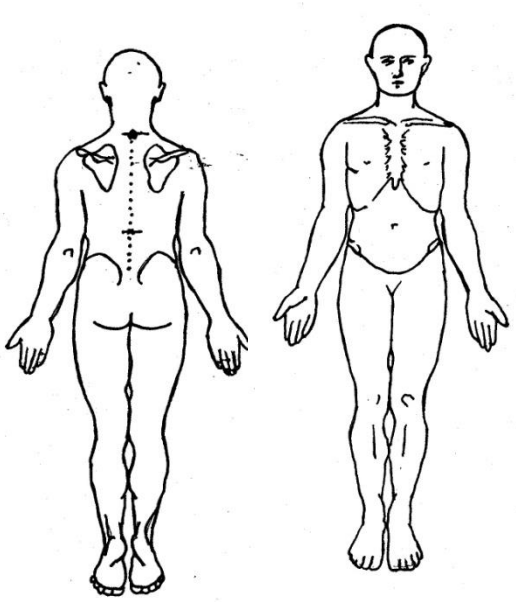
Heart problems	yes	no	_____
Pacemaker	yes	no	_____
Circulatory problems	yes	no	_____
Blood pressure	High	Normal Low	_____
Metal in body	yes	no	_____
Pregnant	yes	no	_____
Smoker	yes	no	Packs/Cigarettes per day? _____
History of cancer (self)	yes	no	_____
Diabetic	yes	no	_____
Osteoporosis	yes	no	_____
Systemic diseases	yes	no	_____
Previous injuries	yes	no	_____
Previous surgeries	yes	no	_____
Previous therapy	yes	no	_____
Asthma	yes	no	_____
Allergies	yes	no	_____

Other:_____
_____
_____

Briefly explain reason for visit. Also mark on diagram location(s): of pain:

_____
_____
_____
_____
_____
_____
_____

_____ _____
SIGNATURE DATE



OFFICE USE ONLY:
TVTD:_____

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MEDICATION NAME	DOSAGE	FREQUENCY	REASON FOR TAKING
1.			
2.			
3.			
4.			
5.			
6.			
7.			
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9.			
10.			
11.			
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13.			
14.			
15.			

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A Patient's Rights

We respect the rights of our patients and recognize that each person is an individual with different needs. We recognize and support patients' rights to participate in health care decisions—including the right to discontinue or refuse treatment to the extent permitted by law.

As a patient, it is your right to:

•Receive considerate and respectful care by competent personnel in a safe environment.
•Be treated without discrimination as to your race, age, religion, sex, sexual orientation, national origin, ability to pay, or illness.
•Be informed of the names of your health care providers.
•Be assured that you will receive physical privacy that is appropriate to the medical care.
•Receive complete and current information concerning your diagnosis, treatment, and prognosis in understandable language. If you cannot understand these elements, we will provide the information to a person you have designated, or we will provide the services of an interpreter.
•Participate in the informed-consent process for any and all treatments and procedures (with the exception of emergency medical care). The informed-consent process includes an explanation of the treatment or procedure; any alternative treatments or procedures; the intent, risks, and possible complications of the treatment or procedure; and the anticipated outcome.
•Formulate advance directives and appoint someone else to make health care decisions to the extent permitted by law.
•Refuse medical treatment, drugs, or procedures, and to be informed of the consequences of your decision.
•Receive complete and adequate discharge instructions after treatment.
•Know that the confidentiality of your medical record contents and the care provided will be protected carefully.
•Expect reasonable continuity of care.
•Participate in the referral process when it is necessary to consult with another health care provider.
•Access the information contained in your medical record. This right may be delegated to another person of your choosing and might include exceptions (such as those pertaining to mental health care or to sensitive materials).
•File a written complaint without fear of retaliation or discrimination.

A Patient's Responsibilities

In acknowledging the personal worth and dignity of each individual, we also recognize that you, as the patient, have certain responsibilities that support the health care we provide. In order to ensure your proper care with the best outcome, it is your duty to comply with our office protocols, which have been designed to promote optimum patient safety.

It is every patient's responsibility to:

•Keep scheduled appointments (or to tell the office when you are unable to keep an appointment).
•Cooperate with the planned treatment program prescribed by the provider (or to explain why cooperation is not possible).
•Take an active role in your medical care.
•Request additional information or clarification when any detail of your medical care is not understood.
•Be honest and accurate in all health care information that you provide to us.
•Update your personal information as necessary to ensure the accuracy of our records.
•Show consideration for other patients and for your health care providers in this office with respectful conduct.
•Be patient when an appointment is delayed; keep in mind that an emergency may be taking place.
•Maintain the same level of confidentiality and privacy for others that you would expect to receive.
•Inform office personnel of any unsafe conditions.
•Be prompt in fulfilling financial obligations to this office.

Our goal is to keep you, our patient, in the best health possible. If you feel that you are being treated unfairly or improperly, please bring it to the attention of your therapist or the office manager.