AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or If Required by Law or Rules

(1) Patient's Printed Name:

_____
Last First Initial or Other

Date of Birth: ____/____/___ Insurance # exactly as on card (including letters)_____

(2) Manual Edge will only disclose the protected health information you want disclosed.
Check only one box to tell Manual Edge the specific information you want disclosed/released:

☐ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)

☐ Limited information (complete ALL Sections)

☐ ALL records regarding my care at Manual Edge to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination _____ Attendance _____ Correspondence re: your Physical Therapy Services
_____ Past Medical History _____ Treatments _____ Other _____

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Other: _____ Other: _____

(5) Check only one box indicating how long Manual Edge can use this authorization:

☐ Disclose my information indefinitely (as long as Manual Edge has custody of my files)

☐ Disclose my PHI for the following period beginning ___/___/_____ and ending ___/___/_____

(6) Please initial all items below indicating that you have read and understand the rights or information below:

_____ I understand that this authorization does not expire unless I have indicated an expiration date above
_____ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_____ I understand that if I give authorization I may revoke it at any time by notifying this Manual Edge in writing
_____ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_____ I understand that if Manual Edge requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_____ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_____ Manual Edge will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

_____ or _____
Signature of Patient **Date** **Signature of Parent or Authorized Representative Date (Indicate the Relationship)**

You May Refuse to Sign this Authorization

Manual Edge Physiotherapy, LLC

6189 Lehman Drive Suite 202

Colorado Springs, CO 80918

No-Show / Cancellation Policy

Please Read Carefully- REVISED 2/2020

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at an efficient level. Due to our one-on-one 50-55 minute treatments, missed appointments are a significant disruption to the clinic, your physical therapist, and other patients.

***Please initial next to each line indicating that you have read and understand the information below**

_____ Please provide our office with a 24-hour notice to change or cancel an appointment. Patients who fail to give 24–hour notice or do not attend a scheduled appointment ("No Show") will be given **ONE** exception. If this should happen more than once, a $75 charge will be incurred for **ALL** future missed incidents. This fee cannot be billed to your insurance company and must be paid on or before your next scheduled appointment.

_____ We reserve the right to dismiss patients from treatment for 3 (three) no shows and/or cancellations with less than 24-hour notice.

_____ We reserve your 50-55 minute appointment time just for you. We do not double-book our patients so that we may provide the highest level of treatment. The 24-hour notice allows us to place another patient in your cancelled appointment time. As we have a waiting list of patients trying to get in for treatment, a missed appointment on your part prevents another patient from getting the help they need.

_____ Certain accident claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your therapist to help you get back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

Signature of Patient _____ Date _____

Manual Edge Representative _____ Date _____

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 REVIEW IT CAREFULLY.

Summary

Confluent Health is required by law to maintain the privacy of individually identifiable health information about you, to provide this Notice of our legal duties and privacy practices, notify affected individuals following a breach of unsecured protected health information and to abide by the terms of this Notice.

We may use or disclose health information about you for the purpose of your treatment, and also to the extent necessary to obtain payment for treatment and for certain administrative purposes, including evaluation of the quality of care that you receive. We may also use or disclose identifiable health information about you without your authorization in certain other circumstances, for example, subject to certain requirements, for public health purposes, for auditing purposes, for research studies, and for emergencies. We also provide your health information when required by law.

Uses or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use or disclosure, you have the right to take back or "revoke" your authorization at any time by submitting a revocation in writing. We are unable to take back any use or disclosure that we have taken an action in reliance on the authorization for use or disclosure as previously indicated.

For additional information, or to make a complaint with respect to your privacy rights, you may contact our Compliance Officer or the Department of Health and Human Services Office for Civil Rights, contact information is listed at the end of this Notice.

Protected Health Information

Protected health information (PHI) is your information created or received by a healthcare provider that relates to your past, present or future physical or mental health or condition, to the provision of health care to you, or to payment for your health care.

How We May Use and Disclose Protected Health Information About You

We may use or disclose your protected health information without your consent or authorization for purposes of your treatment, for payment purposes, and for certain administrative and other health care operations.

Treatment:
We will use and disclose your health information to provide, coordinate or manage health care provided by us and by other health care providers. For example, information obtained by a Therapist or any other healthcare professional will be used to determine and document the course of treatment that works best for you. We will also provide your physician or subsequent healthcare provider with copies of various reports that should assist them in treating you and to continue care.

Payment:
We may use or disclose your health information as needed to obtain payment for health care services we provide. For example, a bill may be sent to you or a claim for payment may be sent to a third-party payer such as an insurance company. The information on or accompanying the bill or claim may include information such as your name, date of birth, social security number and address, as well as your diagnosis and procedures and supplies.

Health Care Operations:
We may use or disclose your health information to run our practice, improve your care and contact you when necessary. These activities include, but are not limited to, quality assessment audits and improvement activities, communication about products or services, conducting training programs, mergers, and development as part of due diligence, business management and general administrative activities.

Business Associates. There are some services provided in our organization through business contracts. When these services are contracted, we may disclose your protected health information to our business associate, so that they can perform the job we have asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your protected health information.

> I acknowledge and understand that this office may contact and survey me via e-mail regarding my satisfaction and outcomes. I understand that an independent vendor(s) may assist with this data collection. I understand that in addition to the aforementioned confidential survey, this office or their designated vendor may also send an automated email to allow me to voluntarily and publicly rate and review my provider online through sites like; Google, Yelp, Keet, etc. I acknowledge that my responses, like other online responses, may be published on the respective review site(s) and will be publicly disclosed and accessible to anyone who accesses that site. I understand that reviews are optional, and I will not include any sensitive, personal, identifying or medial information that I do not wish to be publicly disclosed in an online review i.e. name, contact information, social security number, health history, diagnosis, medications, etc. When submitting a survey or review, I agree to fully release, waive, and indemnify this office and/or the associated vendor(s) from any and all claims arising from my voluntary disclosure of protected health information to the sites.

Other Uses and Disclosures That Do Not Require Your Authorization

- Required by law. We may use or disclose your protected health information if it is required by state or federal law, including the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- Public health and safety issues. Generally, these activities include the following:
  - To notify people of recalls of products they may be using.
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
  - To report suspected abuse, neglect, or domestic violence.
  - To prevent or reduce a serious threat to anyone's health or safety.
- Respond to lawsuits and legal actions. We may disclose protected health information in response to a court order or administrative order, or in response to a subpoena.
- Law enforcement purposes. We may disclose protected health information to law enforcement officials for law enforcement purposes.
- Research. We may disclose your protected health information for health research.
- Special government functions. We may disclose our protected health information for special government functions such as military, national security and presidential protective services.
- Workers compensation. We may disclose your protected health information as permitted or required to comply with worker's compensation laws and other similar legally established programs.
- Medical examiner or funeral director. We may disclose protected health information with a coroner, medical examiner, or funeral director when an individual dies.

Uses and Disclosures to Which You Have an Opportunity to Object

- Individuals involved in your care or payment for care. If you consent, do not object, or we reasonably infer that there is no objection, we may disclose health information about you to a family member, personal representative or other person identified by you who is involved in your health care or payment for your health care. If you are incapacitated or it is an emergency, we will use our professional judgment to determine whether disclosing health information is in your best interest under the circumstances. This includes in the event of your death unless you have specifically instructed us otherwise. You also have the right to request a restriction on our disclosure of your health information to someone who is involved in your care.
- Disaster relief. We may disclose your health information to disaster relief organizations that seek your health information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Uses and Disclosures of Protected Health Information Requiring Your Authorization

- Marketing. Your authorization is required for any use or disclosure of health information for marketing except in situations in which the communication is in the form of a face-to face communication or a promotional gift.
- Sale. Your authorization is required for any disclosure of health information which is a sale, as defined under applicable law.

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information. You will need to give written request in order to exercise these rights. Forms for these purposes are available in our office(s), or you may call the office(s) to request the forms be sent to you.

To request restrictions: You have the right to request that we restrict the uses or disclosures of your information for treatment, payment, or healthcare operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- You have the right to request the non-disclosure of health information if you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

To choose how we contact you: You have the right to ask that we send your information at an alternative address or contact you by an alternative means. For example, you can ask that we only contact you by your cell phone. Request must be made in writing; you do not need to give us a reason for your request. We must agree to your request as long as it is reasonably easy for us to do so.

To inspect and obtain a copy your protected health information: With a few exceptions (such as records compiled in anticipation of litigation), you have a right to inspect or receive copies of your health information. We will provide a copy or summary of your health information, usually within 30 days of your request, we may charge a reasonable cost-based fee.

To request amendment of your protected health information: If you believe that your information is incorrect or incomplete, you have the right to request an amendment as long as the information is maintained by us. We may say "no" to your request, but we will tell you why in writing within 60 days.

To find out what disclosures have been made: You can ask for a list of disclosures of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. Certain types of disclosures are not included such as disclosures about treatment, payment, and healthcare operations, and certain other disclosures, such as any you asked us to make. We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

To receive this notice: You can ask for a paper copy of this notice at any time. We reserve the right to change our Notice of Privacy Practices and to make the new provisions effective for all protected health information we maintain, including protected health information received in the past as well as received after the effective date of the new Notice. A current copy of our Notice will be posted in our office(s) and will also be available on our web site. You may also obtain a copy by writing or calling the office and asking that one be mailed to you or by asking for one the next time you are in our office.

To be notified following a breach. In the unlikely event that your unsecured protected health information has been compromised, Confluent Health will notify you of such an incident.

For questions or complaints, please contact: Compliance Officer Toll free: 888-937-4479

For More Information or to Make a Complaint

If you believe your privacy rights have been violated, you can file a complaint with our Compliance Officer toll free at 888-937-4479 or file an electronic complaint with the Department of Health and Human Services Office for Civil Rights at https://www.hhs.gov/hipaa/filing-a-complaint or call the U.S. Department of Health and Human Services, Office for Civil Rights toll-free at: 1-800-368-1019, TDD: 1-800-537-7697.

There will be no retaliation for filing a complaint.

Effective Date: 8/2020

Patient History Form

NAME: _____ **DATE:** ___/___/____

HISTORY OF PRESENT ILLNESS **Condition Onset Date:** ___/___/___

1. Describe your symptoms in detail: _____

_____

_____

2. This condition: is chronic / is a new injury / occurred for no apparent reason
3. Have you had any diagnostic imaging for this condition? (MRI, Xray, etc)_____

_____

4. What types of doctors/clinicians have you seen for this condition? What treatments have you had for this condition? _____

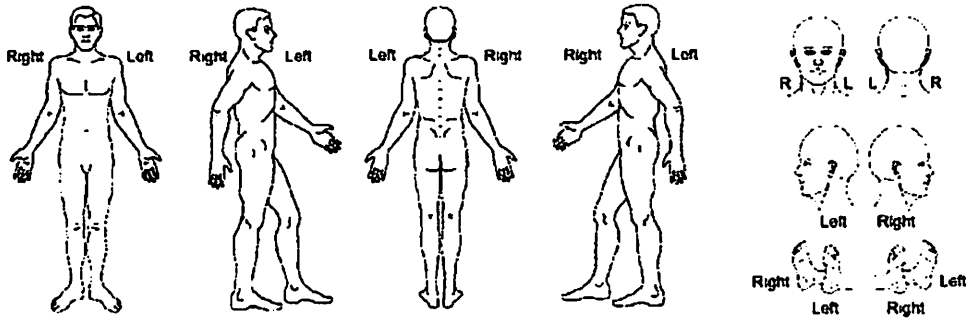
_____

_____

5. Have you had physical therapy for this condition? No / Yes
6. Have you had surgery for this condition? No / Yes:_____
7. What types of everyday, work, or recreational activities are you having trouble doing because of your symptoms?

_____

8. Are your symptoms constant? No / Yes
9. Your symptoms are: Getting better / Getting worse / Staying the same
10. Circle activities that make symptoms worse.
    Bending / Sitting / Turning / Rising / Standing / Walking / Lying / In the AM / As the day progresses / In the PM / When still / When moving / Other: _____
11. Circle activities that make symptoms better.
    Bending / Sitting / Turning / Rising / Standing / Walking / Lying / In the AM / As the day progresses / In the PM / When still / When moving / Other: _____
12. Shade or mark the areas where you experience your symptoms.



PAST MEDICAL HISTORY

13. Living situation: Alone/Family/Other:_____
14. Occupation / Hobbies: _____
15. List and date all surgeries you have undergone:_____

_____

_____

16. List and date all hospitalizations you have had:_____

_____

17. Comments regarding past medical history: _____

_____

_____

_____

18. Current Medications: (Indicate the type, dosage, purpose, and frequency taken.) _____

_____

_____

_____

_____

_____

19. Other comments regarding any of the above information or anything else you would like for us to know.

_____

_____

_____

I certify that this is accurate and complete to the best of my knowledge.

Signature: _____ **Date:** ___/___/___

*Please have guardian co-sign if patient is under 18.