FOREFRONT
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

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, and a plan for future care or treatments. 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.
- Source of information for public health officials charged with improving the health of the nation.
- Tool with which we can assess and continually work to improve the care we deliver and the outcomes we achieve.

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 your healthcare providers, the information belongs to you. You have the right to:

- Request restrictions on certain uses and disclosures of your information (45 CFR 164.522).
- 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 that we notify you when we release your health information.
- 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. Any such revocation must be in writing.

Practice Fusion, our electronic health record provider, stores and maintains all of your physical therapist's notes and other medical-related documents. You may view these documents through your Practice Fusion patient portal. If not given access to your patient portal, please contact Forefront Physical Therapy PLLC for your login.

Our Responsibilities

We are required to:

- Maintain privacy of your health Information.
- Provide you with a notice as to our legal duties and privacy practices with respect to your health information.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment of your 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 Privacy Officer, Daniel H. Benson, at (231) 577-6593. 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.

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment: We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your health care team will then record the actions they took and their observations. In that way, your physicians and other healthcare providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other healthcare providers participating in your care to assist them in treating you if you are referred to them for consultation.

Payment: We will use and disclose your health information for payment. For example, a bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with workers compensation or other similar programs established by law.

Health Operations: We will use your health information within our organization for regular health operations. For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality and effectiveness of the health care and services we provide.

Business Associates: Our organization uses some services provided through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associates so they can perform the jobs we've asked them to do. However, to protect your health information we require the business associates to appropriately safeguard your information.

Family Communication: After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Public Health: As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law.

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INSURANCE & FINANCIAL INFORMATION

In order for most Washington state insurance providers to cover your visit, a referral from your primary care physician is needed to begin treatment with Forefront Physical Therapy PLLC. You must provide us with your physician's name and contact information at the time of your first visit.

General Insurance Information:
To file any claims, we must have the correct insurance information, including: the policyholder's name, date of birth and insurance ID#. If you change insurance companies or if your ID# changes, you must provide us with the new information or you will be responsible for all charges on your account.

Some insurances require authorization to be completed in order for your physical therapy appointments to be reimbursed. We complete these authorizations on your behalf. Please be aware that insurance may deny any physical therapy authorization.

We are a participating provider with the following insurance companies:

- Blue Cross, Blue Shield
- Cigna
- LifeWise
- Medicare
- Worker's Compensation
- Premera
- Regence
- First Choice
- Uniform Medical
- Community Health Plan of Washington
- Group Health Options
- PIP

**You are responsible for any co-payments and deductibles not covered by your insurance plan.

Medicare:
If you have a secondary insurance company, we need that information on file. You will be responsible for any co-payment charges.

Worker's Compensation & Auto Insurance:
We need a doctor's referral and pre-authorization from your Worker's Comp/Auto Insurance carrier in order for your visits to be covered. Please provide your Worker's Comp/Auto Insurance company's name, address, phone number and claim number at the time of registration. If we do not have this information, you will be responsible for your charges.

Self Pay:
You are responsible for paying your bill at the time of your visit. A Payment Plan may be set up if it becomes necessary and if you qualify. If a payment plan is needed, please discuss your options with your physical therapist or office staff.

Patients Under 18 Years of Age:
The adult accompanying a minor is responsible for payment of the minor's account. If there is a financial arrangement with another adult for payment of medical bills, we must receive a signed statement from the individual that he/she is responsible for payment of charges.

Patients (over the age of 18) **When Another Adult Is Financially Responsible For You**:
We must have the financially responsible individual's name, a written statement from that person accepting financial responsibility for your account and an address where we can send your bills. Otherwise, you will be responsible for payment of your account.

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CANCELLATION & NO SHOW POLICY

- **If you need to cancel an appointment, please provide 24 hours notice to avoid a late cancel fee.**
- **You must call or email to cancel (please do not text). If emailing to cancel, please email both the office manager at hello@forefrontpllc.com and your physical therapist at their business email.**
- **Cancellations cannot be made over the weekend.**
- **No shows, late cancellations, and missed appointments are charged directly to you (not your insurance).** We do not double book appointments, so we appreciate your help in cancelling well in advance so that other patients may be scheduled in your place.
- **Each late cancel or missed appointment fee is $75.00.** If you have 3 missed appointments or no shows, you will not be scheduled for future appointments.
- **We accept electronic bank transfers, Visa, MasterCard and American Express.**
- **If you are sent to collections for non-payment, you will be responsible for all collections and legal fees incurred.**

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AGREEMENT FOR FINANCIAL RESPONSIBILITY

1. I understand that I am financially responsible for payment in full of all charges incurred regardless of insurance coverage. If my insurance company denies payment or makes partial payment, I am responsible for the balance due. Further, I understand that Forefront Physical Therapy PLLC has no contracted agreement with any private insurance companies as agreements are between the patient and the insurance company.

2. I hereby authorize payment directly to Forefront Physical Therapy PLLC from my insurance carrier, of benefits otherwise payable to me, such payment not to exceed Forefront Physical Therapy's regular charges for the services performed.

3. I hereby authorized Forefront Physical Therapy PLLC to bill my health insurance for services rendered. If Forefront Physical Therapy PLLC bills my insurance directly, I agree to pay the co-insurance amount that coincides with my insurance policy on a minimum of a monthly basis.

4. If I am unable to make my required payments, a payment schedule will be implemented on the unpaid balance, calling for minimum payments of thirty-three percent (33%) of this balance per month for three (3) months. The required payment is negotiable if significant economic constraints are a factor.

5. I understand that some therapy equipment may not be covered by my insurance company and I agree to pay for the items not covered.

6. I understand that I am responsible for paying any deductible, co-payment, late cancel and/or no show amounts. I understand that co-payments are due at the time of service.

7. I hereby authorize payment of Medicare benefits to Forefront Physical Therapy PLLC for services rendered.

____________________	__________	____________________	____________________
Signature	Date	Print Name	Patient Name [if different]

PROCTECTED HEALTH INFORMATION AUTHORIZATION

Forefront Physical Therapy PLLC's Notice of Privacy Practices provides information about how your health information may be used. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. You acknowledge that if your health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then that information may be re-disclosed and would no longer be protected. You acknowledge that we may sometimes use or release your information without your consent or authorization as may be required or permitted by certain laws.

By signing this Authorization, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You are under no obligation to sign this Authorization. You have the right to review our Notice of Privacy Practices before signing this Authorization. A copy of this Authorization is as valid as the original. The terms of the Notice of Privacy Practices may change at any time.

____________________	__________	____________________	____________________
Signature	Date	Print Name	Patient Name [if different]

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INFORMED CONSENT & LIABILITY RELEASE

The patient and, if applicable, the parent or legal guardian of the Patient, (each, individually or together, herein referred to as "I" or "Me") has been informed of, and acknowledges that, participation in physical exercise involving flexibility, strength, balance, agility, functional training and aerobic exercise, including the use of equipment and devices, is a potentially hazardous activity. I have also been informed, and acknowledge, that participation in physical therapy can be a test of a person's physical and mental limits and that such participation and training poses potential risks of serious bodily injury or death.

I HEREBY ACCEPT THE RESPONSIBILITY FOR ANY HARM, INJURY OR DAMAGE THAT MAY RESULT FROM MY PARTICIPATION IN PHYSICAL THERAPY, FITNESS ENHANCEMENT TRAINING AND OTHER RELATED SERVICES.

I HEREBY WAIVE, RELEASE, ABSOLVE, INDEMNIFY AND AGREE TO HOLD HARMLESS FOREFRONT PHYSICAL THERAPY PLLC, ITS OFFICERS, EMPLOYEES AND AFFILIATES FOR ANY CLAIM ARISING OUT OF ANY INJURY TO ME, WHETHER THE RESULT OF NEGLIGENCE OR ANY CAUSE. I VOLUNTARILY AND KNOWINGLY ACKNOWLEDGE, ACCEPT AND ASSUME THESE RISKS.

I have read this waiver and release of claims and covenant not to sue. I am aware that this is an agreement not to sue and constitutes a complete release of liability by Me. I acknowledge that I am signing this document of My own free will, with full knowledge of the risks being assumed.

I authorize Forefront Physical Therapy PLLC, to administer and perform procedures deemed necessary or advisable in My treatment.

I agree to the following:

1. My participation in physical therapy and training is strictly voluntary.

2. My participation in each and every exercise and activity within the physical therapy training program is voluntary and I may choose not to participate, or limit My participation, in any exercise or activity at any time.

3. I am personally responsible for My own safety while participating in the physical therapy program. I will pace myself to maintain a level of participation that is safe and comfortable for Me.

4. I will advise My physical therapist/physical therapy assistant/trainer of any changes in My physical or mental health prior to participation in each session.

5. My physical therapist/physical therapy assistant/trainer is available to answer any questions or concerns that I might have regarding My participation, activities, or safety.

6. I will seek further direction or explanation of anything that I do not fully understand, or that causes Me concern.

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Signature	Date	Print Name	Patient Name [if different]

EMAIL AGREEMENT FOR BILLING & OTHER COMMUNICATIONS

I authorize Forefront Physical Therapy PLLC, to communicate with me via email as deemed necessary or advisable in My treatment.

I agree to the following:

1. Receiving bills sent via email which include My mailing address, date of birth and legal name.

2. Emails regarding My physical therapy care which may include, but are not limited to, information related to my exercises, health and well-being, scheduling, and communications with other approved healthcare providers.

____________________	__________	____________________	____________________
Signature	Date	Print Name	Patient Name [if different]