Hand Therapy Partners

West Valley Clinic: 623-226-8804 East Valley Clinic: 480-565-2276

Dear Patient

Welcome to our clinic. We are pleased that you have chosen us for your hand therapy. Our goal is to provide you with the highest quality care in a clean and professional environment. Before you begin your therapy program, an evaluation will be performed to assess your individual needs. It is important that you come to your evaluation at least 15 minutes early to complete necessary paperwork.

Appointments. Our patients are seen by appointment only. It is critical that you are on time for your appointments. Being late may make it necessary to shorten your therapy session so as not to disrupt other patients' scheduled appointments.

Attendance Policy. It is very important that you attend all of your scheduled appointments. If you cannot attend, we require that you call **at least 24 hours in advance** so that we can fill your scheduled slot with another patient and schedule a make-up appointment for you.

Inconsistent attendance. If you do not show for your regular appointment, do not call with a 24 hour notice, or are inconsistent in attending therapy, you may be discharged from therapy. Your physician and/or case manager will be notified and you will not be able to return to therapy without a new doctor's order.

Regular attendance and active participation in your therapy program is necessary for you to obtain the maximum benefit from therapy. It is also important for you to have open communication with your therapist about the therapy being provided and any concerns you might have so that therapy can be designed to meet your needs.

Splint Care. If your splint causes any redness or irritation, please contact us as soon as possible so that we can arrange to modify your splint, but remember that it takes time to adjust to wearing a splint. Please keep your splint away from heat sources, such as hot water, car dashboards and the hot sun, because this will cause the splint to soften and lose its shape. Your splint can be cleaned with cool soapy water or we can clean your splint during your next therapy visit. If your splint has rubber bands, they should be replaced 1x/week with the same size rubber bands. A light steady pull on your fingers for a longer period of time is better than a hard pull for a shorter period. And please bring your splint to all of your therapy sessions.

We look forward to working with you.

Hand Therapy Partners

Patient Insurance and Financial Responsibilities

I understand that I am expected to pay for services at the time of service. Depending on my insurance plan, this may be payment in full, a co-payment, a deductible amount and/or co-insurance.

If I am a member of an insurance plan that Hand Therapy Partners (HTP) is not contracted with, I will be required to pay for services in full at the time of service. I can then submit my own claim for reimbursement.

If my insurance company is a managed care plan, it is my responsibility to be sure that necessary referrals and/or authorizations are obtained prior to treatment. If the appropriate referrals and/or authorizations are not obtained, my appointment will be canceled or delayed until this information is obtained. I understand that even though services may be pre-authorized, not all services may be covered or paid for by my insurance plan.

I authorize release of any medical information and/or records necessary to process insurance claims. I authorize HTP to apply for benefits on my behalf for covered services. I also assign all benefits directly to HTP. I certify that the information that I have reported is correct and true. I permit a copy of this authorization to be used in place of the original. My signature below also provides my consent to treat my minor child.

If I am a Medicare beneficiary, I request payment of authorized Medicare benefits on my behalf for any services furnished to me by HTP and authorize HTP to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

I understand I am financially responsible for any charges incurred by me and/or my dependents. I understand that in the event that my account is assigned to a collection agency, I agree to pay an additional collection fee of 10% of the outstanding balance assigned. I also agree to pay any interest on the principal balance, court costs and attorneys' fees associated with the collection of my account.

_____

Patient or Guardian Signature Patient Date of Birth

_____

Printed Name of Patient Date

Acknowledgment of HIPAA Privacy Policies

I understand that as part of my healthcare, Hand Therapy Partners (HTP) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which an insurance carrier can verify that services billed were actually provided
- A tool for routine health care operations, such as assessing quality and reviewing the competence of healthcare professionals

I understand, and have been provided with a Notice of Privacy Practices, which provides a complete description of these uses and disclosures. I have reviewed the Notice of Privacy Practices before signing below. I understand that the terms of the Notice of Privacy Practices may change and then I may request a copy of these changes in writing to the HTP Privacy Officer.

I understand that I have the right to request restrictions as to how my health information is released for the purposes of treatment, payment and health care operations. I understand that I have the right to revoke this consent, in writing, at any time by providing written notification to HTP.

I hereby give consent to HTP to use and/or disclose my protected health information for the purposes of treatment, payment and health care operations. I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to HTP.

_____

Signature of Patient or Personal Representatives Patient Date of Birth

_____

Printed Name of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

Hand Therapy Partners

Authorizations to Use/Disclose Protected Health Information

West Valley Clinic **9130 W Thomas Rd #A-105, Phoenix, AZ 85037** **P: 623-226-8804** **F: 602-532-7839**

East Valley Clinic **430 N Dobson Rd #103, Mesa, AZ 85201** **P: 480-565-2276** **F: 480-383-6789**

I hereby authorize the use and/or disclosure of all of my personal health information by Hand Therapy Partners as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan or healthcare provider, the release information may be re-disclosed and may no longer be protected by the federal privacy regulations.

1. Person or organization authorized to receive the health information:

   _____

   _____

2. Description of each purpose for which the health information will be used/disclosed (Note: Not required if disclosure is requested by the individual):

   _____

   _____

3. I understand that the person or organization that I am authorizing to use/disclose the information may receive compensation in exchange for the health information described above.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits.* (Note: Not required if disclosure is requested by the individual).

5. I understand that I may revoke this authorization at any time by providing written notice to: Cary B. Edgar, Hand Therapy Partners LLC, 3241 E. Camelback Road, Phoenix, AZ 85018. I understand that my revocation will not affect any action already taken in reliance on this authorization.

6. I understand I may inspect or copy any information to be used or disclosed under this authorization.

7. Unless otherwise revoked in writing, this authorization will automatically expire one year from the date I sign below.

_____ _____

Signature of Individual (or Legal Representative) Date

_____

Individual's Name (Print)

_____ _____

Name of Legal Representative, if applicable (Print) Relationship

*A health plan may condition enrollment or eligibility for benefits on an individual providing an authorization prior to enrollment if the authorization sought is for the plan's eligibility or enrollment determinations relating to the individual or for its underwriting risk or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes (45 C.F.R. § 164.508(b)(4)(ii)(A&B)).

Hand Therapy Partners

Today's Date _____

Patient First Name _____ MI _____ Last Name_____

Date of Birth _____

Gender: ☐Male ☐Female

Address_____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Cell Phone_____

Responsible Party:

Name: _____Relationship to Patient _____

Address (if different from above) _____

City _____ State _____ Zip_____

Primary Contact Phone Number _____

Primary Insurance_____

Member ID # _____ Group # _____

Insured Name _____ Insured Date of Birth _____

Insured Relationship to Patient _____

Secondary Insurance _____

Member ID # _____ Group # _____

Insured Name _____ Insured Date of Birth_____

Insured Relationship to Patient _____

Emergency Contact _____Phone _____

Hand Therapy Partners

Today's Date _____

Patient's Name _____ Date of Birth _____

Date of Injury _____ Date of Surgery _____

Is this related to an accident? ☐Yes ☐ No

If accident: ☐Work ☐Auto ☐Other: _____

Injured area: _____ ☐ Left ☐ Right

How did injury occur?

_____

_____

_____

_____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

Therapy/Splint goals _____

Allergies _____

Current Medical Conditions: ☐Hepatitis/HIV ☐ Diabetes ☐ Cardiac Problems ☐ Cancer

Other: _____

Current Medications _____

Are you receiving, or have you recently received home health services? ☐ Yes ☐ No

Are you receiving, or have you recently received other therapy services? ☐ Yes ☐ No

Hand Therapy Partners

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit cms.gov/nosurprises or 1-800-985-3059.

Hand Therapy Partners

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- 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. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) 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.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan, so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Our Privacy Officer

Our privacy officer, who can be contacted regarding any privacy issues, is:

Cary Edgar
Hand Therapy Partners LLC
522 N Central Ave #679
Phoenix, AZ 85001
Email: cedgar@handtherapypartners.com
Phone: (480) 206-6240

Effective Date: As of January 1, 2022