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
-Market our services and sell your information
-Raise funds

Our Uses and Disclosures

We may use & 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
- Address workers' compensation, law enforcement & 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:

Foundation Physical Therapy,
LLC Attn: HIPAA Privacy Officer
12 Waite Street, B1
Greenville, SC 29607
864-214-6680

-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
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
-Most sharing of psychotherapy notes
In the case of fundraising:
-We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.

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.

-Effective Date of this Notice:
January 12, 2023

Date:_____/_____/ _____

Last Name_____First name_____MI_____Preferred Name _____

Birth Date____/_____/ _____ Age ___ Sex: M F (*please circle*) Marital Status: S M W D P (*please circle*)

Address (mailing)_____City_____State_____Zip _____

Address (physical)_____City_____State_____Zip _____

Email Address_____Social Security #:_____/_____/ _____

Home Phone (___) -_____-_____Cell (_____) -_____-_____Work (_____) -_____- _____

Can we leave a detailed message on:_____Phone_____Email:_____

Emergency Contact_____Phone (_____) -_____-_____Relationship _____

Current Employer_____Occupation _____

Were you injured on the job? Yes No Date of injury____/_____/_____Claim #_____
Name of Adjustor_____Phone (_____) -_____- _____
Name and address of Employer at time of Accident: _____

Were you injured in a car accident? Yes No Date of injury__/_____/ _____ State___Claim #_____

Name of Adjustor_____Phone (_____) -_____-_____
Name of Attorney_____Phone (_____) -_____- _____

Primary Insurance or Workers Comp	**Secondary Insurance**
Complete Blanks using INSURED'S information	*Complete Blanks using INSURED'S information*
Insurance Company _____	Insurance Company _____
Insured's ID#: _____	Insured's ID#: _____
Group#_____	Group#_____
Insured's Name _____	Insured's Name _____
Birth Date____/_____/ _____	Birth Date____/_____/ _____
Patient's relationship to insured _____	Patient's relationship to insured _____
Employer _____	Employer _____

Name of person responsible for bill_____SS #:_____/_____/ _____
Address of person responsible_____City_____St_____Zip _____

PLEASE NOTE: This agreement is between Foundation Physical Therapy, LLC and Customer. If full payment is not received by the Customer's insurance company, or if the Customer has no insurance, the unpaid balance remains the responsibility of the Customer and is due within fourteen (14) days from the date of the invoice. See TERMS AND CONDITIONS for more details.

I have read and understand the additional TERMS AND CONDITIONS set forth in this document, which I hereby agree to.

_____ _____ /_____/ _____
Patient/Guardian Signature Date
(*Person responsible for the bill and/or Legal Guardian if Patient is under the age of 18)*

1/12/23.

Payment is expected at the time services are rendered; other arrangements must be made prior to treatment.

TERMS AND CONDITIONS
Foundation Physical Therapy, LLC

COMMERCIAL/GROUP INSURANCE: (BlueCross, Aetna, Cigna, etc.): After verification of coverage with your insurance company/companies, we will file a claim as a courtesy to you. We reserve the right to release information for insurance purposes. If your deductible has not been met or cannot be verified**, WE WILL REQUIRE THE PAYMENT OF YOUR DEDUCTIBLE AMOUNT**. We then require that you pay the Co-pay/Coinsurance due by you, at the beginning of each visit. We will allow 45 days for your insurance company to pay assigned claims, after which time we will hold you, the patient, responsible for payment of your account.

WORKERS' COMPENSATION: We will verify your workers' compensation coverage with your employer or the company where you were employed at the time of your accident. After verification, we will file your claims for you. If your Workers' compensation is denied for any reason, YOU will be responsible for your bill. If we have to file your group insurance (because your Workers' Compensation was denied), any amount not paid by your group insurance will be YOUR responsibility. (Please give us your group health insurance so we can have a copy on file should your workers' compensation be denied) Missed appointments will be reported to your employer, case manager, physician, and documented in your clinical record. Missed appointments may lead to the disruption of your workers' compensation payments if you do not follow the directives of your physician for treatment.

MEDICARE: You are responsible for the annual $226 deductible. Medicare will only pay for physical therapy after expenses exceed $226. Medicare will then pay 80% of the allowable charges. Therefore, YOU are responsible for the remaining 20%. If you have secondary insurance coverage and provide us with that information, we will bill your secondary insurance as a courtesy to you. If you do not have secondary insurance or your secondary insurance fails to pay for your services, YOU are responsible for the payment of the 20%. If Medicare denies charges because you have other insurance that is considered primary insurance, you will be responsible for all incurred charges. Please inform us of any other insurance coverage that you may have.

AUTO ACCIDENT/ATTORNEY: If you have been involved in an accident and have an attorney representing you, we require a letter of protection from your attorney prior to beginning treatment. If you have been in an accident, we also require your adjuster's name and contact information along with a claim number prior to beginning treatment.

Additionally, we require that you sign the Patient Authorization and Consent form in our New Patient Packet.

NO INSURANCE: This agreement is between Foundation Physical Therapy, LLC and Customer. If full payment is not received by the Customer's insurance company, or the Customer has no insurance, the unpaid balance remains the responsibility of the Customer and is due within fourteen (14) days from the date of the invoice.

COSTS, ATTORNEY'S FEES, AND INTEREST: The Customer agrees to pay all invoices upon receipt of the invoice. In the event of default, defined as not receiving payment within two weeks from the date of the invoice, interest shall accrue on the unpaid balance at the rate of 1.5% per month (18% per annum). The Customer also agrees to pay all reasonable attorneys' fees and costs incurred in collecting any past due amounts.

CANCELLATION/NO SHOW POLICY: In order to receive the maximum benefit from your physical therapy, it is important to keep your scheduled appointments. We have dedicated an appointment time and paid staff members to be here for your scheduled appointment. Therefore, if you fail to attend your scheduled appointment, or do not call to cancel or reschedule your appointment within **24 hours** of your scheduled appointment time, you will be charged a **$50.00 Cancellation Fee** to be paid at your next visit. If you cancel or fail to show for three (3) consecutive appointments, you may be discharged from therapy. In the event of an actual emergency where prior notice could not be given, consideration will be given, and an exception may be granted.

I have read the above policy and fully understand my responsibilities.

Patient/Guardian Signature: _____ Date: _____

PATIENT AUTHORIZATION AND CONSENT

I hereby consent to treatment.
I authorize Foundation Physical Therapy, LLC and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

I have received Foundation Physical Therapy, LLC's Notice of Information Practices. I understand that Foundation Physical Therapy, LLC and its subsidiaries and affiliates may use or disclose my personal health information to my insurance company, rehab nurse, case manager, attorney, employer, school, relate healthcare provider, assignees and/or beneficiaries and all other relates persons as it relates to my treatment. I understand that I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that Foundation Physical Therapy, LLC will consider requests on a case-by-case basis but does not have to agree to requests for restrictions.

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize the payment of medical benefits directly to Foundation Physical Therapy, LLC for the services rendered. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered effective and valid as the original.

I hereby authorize one or all of the designated parties below to request the release of and receive any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name & Relationship _____
Name & Relationship _____
Name & Relationship _____
Name & Relationship _____

Payment Guarantee: I agree to pay Foundation Physical Therapy, LLC, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as Workers' Compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Foundation Physical Therapy, LLC and/or its affiliates or subsidiaries.

Patient/Guardian Signature: _____ Date: _____

BRIEF MEDICAL HISTORY

Patient Name: _____
Reason for Therapy: _____
Referring Doctor:_____Primary Care Physician:_____
Who may we thank for referring you to Foundation PT?_____
How did injury occur? _____
Date of Injury: _____
Have you received therapy for this injury? Yes No If yes, when? _____
Type of treatment. Was it successful_____
Have you received Home Healthcare Services within the past 30 days?_____
What aggravates your symptoms? _____
What relieves your symptoms? _____
Please rate your pain between 0 and 10 (***0*** *is no pain,* ***10*** *is likened to child birth or passing a kidney stone*)
At worse:____ Present____At best _____

Do you now, or have you in the past, had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes			Current Infections			Previous Fractures		
Arthritis			Heat/Cold Hypersensitivity			Osteoporosis		
High Blood Pressure			Allergies			Depression		
Heart Disease			Hernia			Anxiety		
Heart Attack			Presently Pregnant			Substance Abuse		
Pacemaker Implant			Seizures			Controlled Substance Abuse		
Vascular Disease			Metal in Body			Tobacco Use		
Headaches			Cancer/Tumor			Alcohol Use		
Kidney Problems			Thyroid Problems			Previous Surgeries		
Open Wounds			CVA/Stroke			Other		

If you answered yes to any of the above, please explain and give approximate dates:

_____
_____
_____

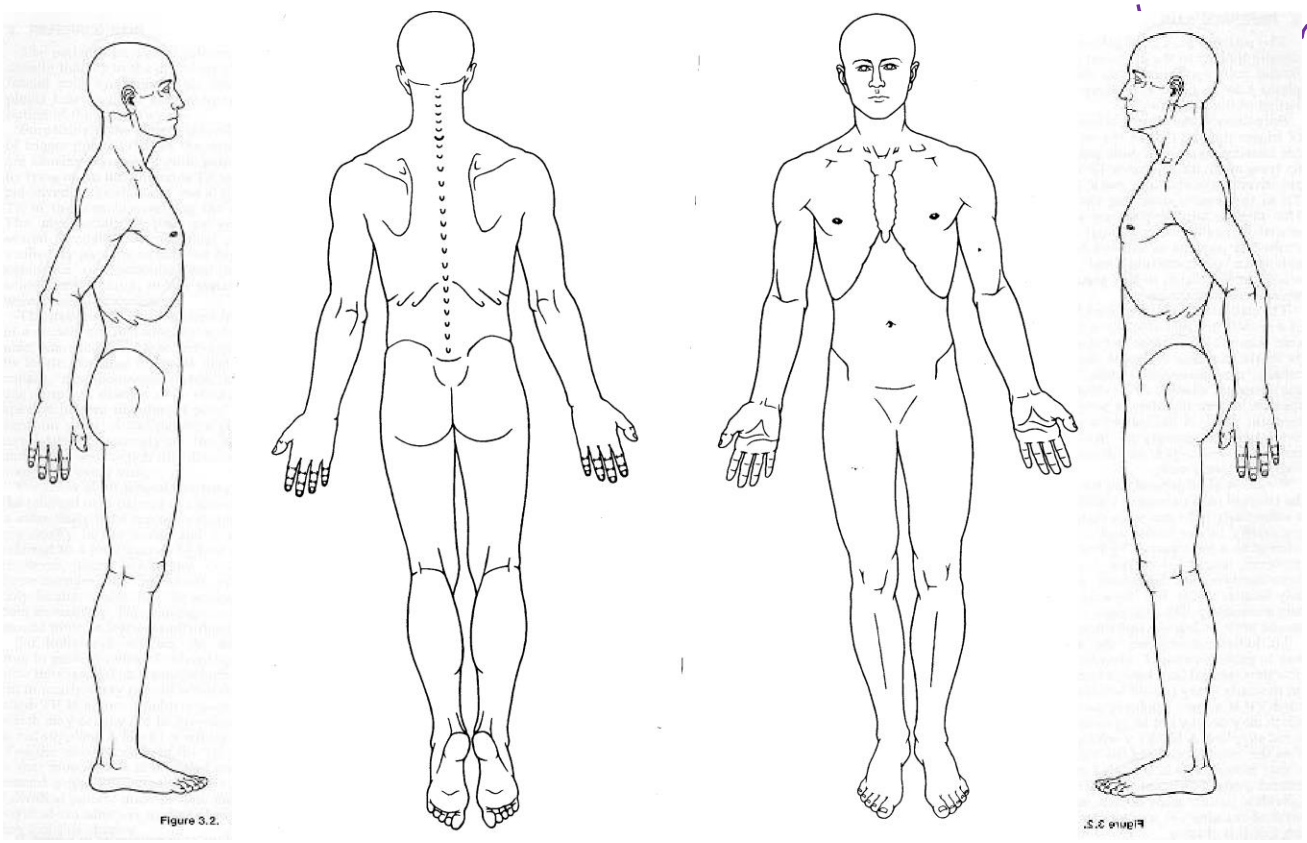
Please list all current medications (prescriptions, over-the-counter, herbals, vitamins/minerals/dietary/nutritional supplements) and specify dosage:

_____
_____
_____
_____

The information above is correct to the best of my knowledge. If anything changes, I agree to notify Foundation Physical Therapy, LLC and update this form.

_____ _____
Patient/Guardian Signature Date

Pain Drawing



Relating to your present injury or condition

Indicate where your pain is located and what type of pain you feel at the present time.
Use the symbols below to describe your pain.

/ / / /	Stabbing
X X X	Burning
O O O	Pins and Needles
= = =	Numbness

Patient-Specific Activity Scoring Scheme

Name:_____

Date: _____

Please list at least 3 activities that are affected by your symptoms. Then rate how this activity is influenced by the symptoms.
0 = no pain with the activity, symptoms do not interfere with the activity.
10 = extreme pain, unable to perform the activity due to symptoms, must go to the emergency room. Mark on the line, the degree of difficulty you have with the activity because of symptoms.

Activity	**Difficulty Level**
1. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
2. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
3. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
4. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
5. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
6. _____	_____ 0 1 2 3 4 5 6 7 8 9 10