COAST Rehabilitation Privacy Agreement, Privacy Practices, HIPAA Patient Acknowledgement, Payment Agreement, and Cancellation Agreement

* Required

1. **Email address** *

2. **Name** *

3. **Date** *

   Example: December 15, 2012

Patient Privacy Agreement

Authorization form for use and disclosure of health information:

COAST Rehabilitation Services is required by law to maintain the privacy of our patient's health information. Unless you have signed a form authorizing the use or disclosure: we will not use of disclose your health information for any purpose other than CAOST's role in treatment, payment of for health care operations. With your written approval, we may disclose your health information to others including designated family, friends, or others who are involved in your health care or payment for your health care. This form allows you to designate this/these person(s). A copy is as valid as the original.

4. **I hereby authorize the use or disclosure of health information about me as described below. As the parent/guardian I authorize the use or disclosure of health information about my minor dependent.** *

   Check all that apply.

   - [ ] I agree

5. **Person or group authorized to disclose information: COAST Rehabilitation** *

   Check all that apply.

   - [ ] I agree

6. **Person or group authorized to receive and use information from COAST rehabilitation Services. Please list the names of your spouse, family, and/or friends you may want info disclosed to. Please list their address and relationship as well. If none, write "none". At minimum, by signing at the end of this document, you agree that your current insurance provider is authorized to receive and use information from COAST rehabilitation services.** *

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Privacy Practices and HIPAA Patient Acknowledgement

Notice of Privacy Practices:

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTIES:
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect (01/01/08), and will remain in effect until we replace it.

We reserve the right to change our privacy practices ant the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms or our notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may also request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION:
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your local health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot us or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-related services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

national Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a certain amount of money reflecting the amount of pages required, postage (if you want copies mailed to you), and hours of staff time to locate and copy your health information. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end f this notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our

business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You may have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why information should be amended.) We may deny your request under circumstances.

Electronic Notice: If you receive this notice on our website or by electronic mail (email), you are entitled to receive this notice in written form.

7. **I acknowledge that I have received a copy of the Notice of Privacy Practices of COAST Rehabilitation Services, Inc. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of the any amend Notice of Privacy Practices at my next appointment.** *

   Check all that apply.

   - [ ] I agree

Payment Agreement

To all new and established patients:

8. **Providing you have medical insurance benefits and you elect to use those benefits for services rendered, COAST Rehabilitation Services will submit your claims to your insurance company and payment will be assigned to COAST. It is important that you contact your insurance company benefits department DIRECTLY and obtain specific limits, benefits, deductibles/ copayment or any other information regarding your rehabilitation or physical therapy treatments. Every effort is made to collect your benefits from your insurance company. However, you re solely responsible for all charges incurred and we will expect payment for denied, non-covered and patient responsibility amounts as directed by your coverage.** *

   Check all that apply.

   - [ ] I have read the above information, and acknowledge and agree to all the information.

Cancellation Agreement

To all new and established patients:

9. **Patients not calling (24 hour notice) or showing for your scheduled appointment may result in a $45 fee. This fee will be collected on the next scheduled appointment. It must be paid with cash, check, or credit card. Insurance will not pay for this fee.** *

Check all that apply.

- [ ] I agree

Acknowledgement and Agreement

10. **I agree to the California Orthopedic and Sports Therapy Rehabilitation Services, Inc. Patient Privacy Agreement, Privacy Practices, HIPPA Patient Acknowledgement, Payment Agreement and Cancellation Agreement.** *

Check all that apply.

- [ ] I agree

11. **Signature** *

A copy of your responses will be emailed to the address you provided