Tri Fit Physical Therapy & Wellness

Payment Policy and

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Additional information is available from the U.S. Department of Health and Human Services, http://www.hhs.gov.

HIPAA provides certain rights and protections to you as the patient. Tri Fit PT & Wellness supports these needs in our goal of providing you with quality professional service and care.

We have adopted the following policies:

- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information, which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
- You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
- You agree to bring any concerns or complaints regarding privacy to the attention of the staff or Celeste Rice.
- Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Authorization for treatment, payment & healthcare operations

I authorize the release of my medical/my child's medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to Tri Fit PT & Wellness, its successor, or any individual it may designate for services provided.

Signature of Patient/Legal Guardian: _____

HIPAA Agreement

Under HIPPA Privacy Regulations a patient may allow access to his/her Protected Health Information (PHI)

_____I DO NOT want any information given out

_____I give permission to leave a message on my: ___HOME PHONE ___CELL ___WORK

_____I give my permission to discuss test / lab results medical record with:

Name: _____ Relationship:_____Phone: _____

Financial Agreement & Cancellation Policy

I understand that if my health insurance *denies* me payment for therapy services, I agree to pay TRI FIT PT & Wellness for any and all of my unpaid billable treatments at regular rates until such time that my insurance company gives me authorization for payment. By signing this I am confirming that I have verified TRI FIT PT & Wellness is a participating in-network provider or if out-of-network, I have personally confirmed my network benefits with my insurance.

Signature of Patient/Legal Guardian: _____

Cancellation Policy

A 24-hour notice is required for cancellation of any appointments
Please note, there will be a **$30.00** fee will be charged if an appointment is cancelled with less than 24-hour notice. A **FULL** service fee of **$85.00** will be charged for **NO SHOW** appointments or cancellations within an hour to appointment.

Signature of Patient/Legal Guardian: _____

FOR MEDICARE PATIENTS ONLY

Medicare Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of authorized Medicare benefits be made either to me or on my behalf. I understand I am responsible for any balance unpaid by Medicare for billable services. I understand I am responsible for any services not covered under Medicare.

Signature of Patient: _____

I,_____, on this date_____do hereby consent and acknowledge my agreement to the terms set forth in this HIPAA INFORMATION AND CONSENT FORM. I understand that this consent shall remain in force from this time forward.

Signature of Patient/Legal Guardian: _____