



CALHOON ORTHOPAEDIC EXERCISE & REHABILITATION

HEALTH INFORMATION PRIVACY UNDER HIPAA

Your privacy is of utmost importance to us, and Federal law says that you must be informed of your rights and our responsibilities in protecting the confidentiality of every aspect of your treatment at Calhoon Orthopaedic Rehabilitation & Exercise. The "Privacy Rule" gives you rights over who can access any of your health information, and how it is shared. The Security Rule gives added protection over electronic health information, such as emails we send and receive, and our electronic medical records system.

TO PROTECT YOUR INFORMATION, WE ARE REQUIRED TO

- Put safeguards in place to protect it.
 - Reasonably limit use and disclosures to the minimum necessary to accomplish their intended purpose.
 - Have contracts in place with our contractors and others ensuring that we use, disclose, and safe guard your health information properly.
 - Have procedures in place to limit who can view and access your health information.
 - Implement training programs for employees about how to protect your health information.
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UNDER THE PRIVACY RULE, WE MUST COMPLY WITH YOUR RIGHT TO

- Ask to see and get a copy of your records
 - Have corrections added to your information
 - Receive a notice that tells you how your information may be used and shared
 - Decide whether to give permission before your information can be used or shared
 - Get a report on when and why your information was shared for certain purposes
 - Ask us questions about your rights
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WE ARE ALLOWED TO SHARE YOUR INFORMATION IF IT IS NECESSARY

- For your treatment and care coordination
 - To relate details about your physical therapy to medical providers involved in your health care
 - With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills, unless you object
 - To make sure your medical provider is informed of any recent changes in your health care
 - To protect the public's health
 - To make required reports to the police, such as child abuse or suicide attempt.
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UNLESS YOU GIVE PERMISSION, WE CANNOT

- Give your information to your employer
 - Use or share your information for marketing or advertising purposes
 - Share details about your care with anyone outside your healthcare team
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IF YOU FEEL WE HAVE VIOLATED YOUR RIGHTS UNDER THIS LAW, YOU CAN

- File a complaint with your provider or health insurer
 - File a complaint with the U.S. Government
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FOR MORE INFORMATION, INCLUDING HOW TO FILE A COMPLAINT, VISIT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES WEBSITE AT: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html> OR CALL 800.368.1019.



CALHOON ORTHOPAEDIC REHABILITATION & EXERCISE

NOTICE OF FINANCIAL POLICIES

COSTS OF OCCUPATIONAL THERAPY

Depending on your insurance coverage, the actual cost of therapy to you may vary. The initial evaluation ranges from \$305-\$410 depending on complexity. Treatment ranges from \$210-\$315 depending on procedure time-frame. Upon your request, we will supply you with a more detailed fee schedule for therapy services. Please ask about our interest-free payment plan for any expenses not covered by insurance.

Please initial _____

INSURANCE BILLING, AND YOUR RESPONSIBILITIES

As a courtesy, we will bill your insurance and have payments sent directly to us. You will be responsible for verifying your insurance eligibility and coverage. You will be responsible for any deductible or co-payment at the time of service. After insurance pays its portion, you're responsible for the remaining balance, with some exceptions. Many insurance companies, because of our contractual agreements with them, limit the amount that can be billed for therapy (the "allowed amount"), and place a limit on what patients must pay. We encourage you to call your insurance company with some questions about your policy (see the document "Calling Your Insurance Company"), take notes, and bring the form to your first therapy visit. If your insurance changes, please let us know as soon as possible, to avoid insurance denial of a claim.

Please initial _____

AUTO INSURANCE (Third-party) BILLING, Restrictions

Most auto insurance claims are subject to limits on medical care. A primary medical insurance must be listed on the registration form. Your medical insurance will be billed for any claims denied by auto insurance and you must meet the deductible and co-pays.

CANCELLATIONS AND MISSED APPOINTMENTS

We understand if you need to adjust your schedule or cancel an appointment. Please give us advanced notice to avoid any fees or schedule limits. Failure to call or show for a scheduled appointment will require payment of the No-Show fee (\$50) to keep future appointments on the schedule.

Please initial _____

PAYMENT AND BILLING

All co-pays and deductibles must be paid at the time of service. If you have concerns about the cost of your care, please ask us about our reasonable Payment Plans.

Please initial _____

We accept payments of cash and credit card.

PLEASE FEEL FREE AT ANY TIME TO ASK FOR CLARIFICATION OF THESE POLICIES, OR TO DISCUSS ANY FINANCIAL CONCERNS YOU MAY HAVE. Thank you for your time.



CALHOON ORTHOPAEDIC REHABILITATION & EXERCISE

CALLING YOUR INSURANCE COMPANY

INSTRUCTIONS: We will bill your insurance as a courtesy to you. It is important and necessary to be informed about your health benefits under your insurance policy, so that you may make informed decisions about purchasing health care services. If you will be using any private, non-government-sponsored health insurance to pay for therapy (including secondary insurers), we ask that you take a few minutes and call the toll-free number on your insurance card to verify your eligibility and coverage.

WHAT TO SAY: "I'd like to ask some questions about my outpatient occupational therapy benefits." Then ask them the following questions, write down the answers, and bring the completed form with you to your first occupational therapy visit.

1. Do I need a prescription from a medical provider for therapy?
2. What is my co-pay / co-ins for an occupational therapy visit?
3. How many visits are allowed?
4. How many visits have I used to date?
5. What is my annual deductible for outpatient occupational therapy?
6. How much of my deductible have I met?
7. When does my "benefit year" start (beginning of the calendar year or not)?
8. Do I need pre certification for Occupational Therapy?
9. Do I need pre-authorization? If so, what number do I call? (If this is required, please call the number before your first visit.)
10. What rules apply to my authorization? For example, do I have to get re-authorized after a certain number of visits, or every year on a certain date?
11. Do I have "out-of-network" benefits for outpatient occupational therapy services? If so, please summarize them.



CALHOON ORTHOPAEDIC REHABILITATION & EXERCISE

Patient Demographics

Patient Information

Name _____ Preferred Name _____

Social Security# _____ Date of Birth _____

Phone _____ Gender: Male/Female/Non-Binary (circle)

Address _____

How did you hear about Calhoon Orthopaedic Rehab? _____

Email (for appointment reminders):

Patient Employment Information

Employment Status (circle) Full/Part Time/Retired/Unemployed/Disabled/Student

Occupation _____ Employer _____

Address _____ Phone _____

Patient Emergency Contact

Name _____ Relationship to Patient _____ Phone _____

Responsible Party (if under 18yo)

Name _____ Relationship to Patient _____ Date of Birth _____

Phone _____ Address _____

Consent to Treat

I authorize Calhoon Orthopaedic Rehabilitation & Exercise to examine me, administer treatment as necessary, and perform procedures that are considered therapeutically or diagnostically necessary.

Signature _____ Date _____ Relationship to Patient _____

Release of Information

I authorize the release of information to the following individuals. I understand that only the individuals listed below will be able to obtain information regarding myself (including date and time of appointments):

- (1) _____
- (2) _____
- (3) _____
- (4) _____



Administrative Agreement

Restoring your health requires commitment and consistency. It's important to attend appointments as scheduled to get results. Please review and initial below to acknowledge your understanding of the following expectations:

_____ Failure to notify us prior to missing your scheduled appointment (No-call / No-show) will result in \$50 fee charged to you, not to your insurance company. You will be required to pay this fee, with credit card or cash, before scheduling any future appointments.

_____ If you arrive more than 15 minutes late for your scheduled appointment time, you may be rescheduled.

_____ Excessive cancellations may result in schedule limitations.

Your financial responsibility is determined by your insurance company as reflected on the explanation of benefits (EOB's) which you will receive from your insurance provider. We have payment plans available for clients experiencing financial difficulty due to insurance deductibles.

- It's necessary for all fees (copays and deductibles) to be collected at the time of service. If you wish to keep your credit card on file, you give Calhoon Orthopaedic Rehabilitation & Exercise permission to charge said credit card on the date of your scheduled appointment for the amount due for the services rendered.
- We will maintain an accurate record of all payments and charges. However, in the rare case that an overpayment occurs, your account will be credited at the end of your therapy treatment.
- All credit card transactions will generate a receipt which is available at your appointment date or via email. If the credit card information we have on file changes for any reason, please notify us as soon as possible.

I have reviewed and understand the information on this page

Client's Name: _____

Signature: _____ Date: _____



CALHOON ORTHOPAEDIC REHABILITATION & EXERCISE

Medical History Form

(All answers are optional and confidential. You may leave this form uncompleted if you wish to go over it in person)

Name	Date of Birth	Age
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SECTION I: THE CURRENT PROBLEM

What brings you to occupational therapy? What is the problem?

When did this problem first occur (date of onset)? Was there a certain event that caused it?

Where is the problem? What part(s) of your body?

What makes it better?

What makes it worse?

Anything else you would like to discuss?

SECTION II: SOCIAL HISTORY (each of these questions is optional)

With whom do you live, and what is (are) there relationship(s) to you?

What activities (aside from work) do you enjoy doing or need to do for daily life? How are they limited by this problem?

Do you consume alcohol? If so how many drinks per week?

Do you consume tobacco? If so how much per week?

SECTION III: OCCUPATIONAL HISTORY

What do you do or did you do for a living?

How many hours do you (or did you) work in a typical week?

If you have retired or stopped working, when?

How would you describe your work duties?



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SECTION V: MEDICATIONS & ALLERGIES

Please list prescriptions, over-the-counter medications, or nutritional supplements that you take (or attach a list):

PLEASE LIST ANY KNOWN ALLERGIES (i.e. nickel):

SECTION V: PERSONAL AND FAMILY MEDICAL AND SURGICAL HISTORY

Have you been diagnosed with or treated for any of these? (Check any that apply)

- | | |
|--|--|
| <input type="checkbox"/> Breathing or lung (respiratory) problems | <input type="checkbox"/> Digestive problems (throat, stomach, bowels) |
| <input type="checkbox"/> Problems of the heart or blood vessels (cardiovascular) | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Blood pressure or cholesterol problems | <input type="checkbox"/> Kidney (renal) problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver (hepatic) problems (hepatitis, cirrhosis, etc.) |
| <input type="checkbox"/> Infections or infectious disease | <input type="checkbox"/> Cancer, past or present |
| <input type="checkbox"/> Bone and joint (musculoskeletal) injuries or disorders | <input type="checkbox"/> Stroke (cerebrovascular accident) |
| <input type="checkbox"/> Depression, anxiety, or other psychological disorders | <input type="checkbox"/> Blood disorders (clots, easy bleeding, anemia, etc.) |
| <input type="checkbox"/> Alcohol or drug addiction, overuse, or abuse | <input type="checkbox"/> Head injury or trauma (including that by violence) |
| <input type="checkbox"/> Hereditary disorders or diseases | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Glandular (endocrine) disorders (thyroid, prostate, etc.) | |

Please list any close blood relatives who have been significantly affected by any of these:

Have you recently had any of these? (Check any that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Unusual lumps |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Worsening pain at night | <input type="checkbox"/> Stiffness in many joints |
| <input type="checkbox"/> Bleeding or bruising | <input type="checkbox"/> Fainting or blackouts | <input type="checkbox"/> Constant, relentless pain |
| <input type="checkbox"/> Leg cramps, redness, or tenderness | <input type="checkbox"/> Dizziness or lightheadedness | <input type="checkbox"/> Confusion or forgetfulness |
| <input type="checkbox"/> Recent change in weight, appetite | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Implants _____ |
| <input type="checkbox"/> Feeling fatigued, weak, or sick | <input type="checkbox"/> Trouble swallowing | |
| <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Unusual skin changes, sensations | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Urinary or bowel changes/problems | <input type="checkbox"/> Other: _____ |

Please list any surgeries you've had with approximate dates:

SECTION VI: SAFETY:

Have you fallen recently during normal daily activity?

Do you feel safe at home?

Have you felt threatened, controlled by, or afraid of a partner, family member, or caregiver?

Do you have any other concerns you wish to discuss confidentially?



CALHOON ORTHOPAEDIC REHABILITATION & EXERCISE

Notice of Privacy Practices

This Notice describes how Calhoon Orthopaedic Rehabilitation & Exercise LLC may use and disclose your healthcare information and how you can obtain access to this information. Please review it carefully. Calhoon Orthopaedic Rehabilitation & Exercise LLC is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Calhoon Orthopaedic Rehabilitation & Exercise LLC or received by Calhoon Orthopaedic Rehabilitation & Exercise LLC from other healthcare providers. We are required to provide you notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this notice. Calhoon Orthopaedic Rehabilitation & Exercise LLC will abide by the terms of this notice, or the notice currently in effect at the time of the use or disclosure of your protected health information. Calhoon Orthopaedic Rehabilitation & Exercise LLC reserves the right to change the terms of this notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised notices upon request. An individual may obtain a copy of the current notice from our office at any time.

Uses of Disclosures of Your Protected Health Information Not Requiring Consent:

Calhoon Orthopaedic Rehabilitation & Exercise LLC may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment, and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment May Include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers.
- Consultations between healthcare providers concerning a patient.
- Referrals to other providers for treatment, including nursing homes, foster care homes, or home health services.

For example, Calhoon Orthopaedic Rehabilitation & Exercise LLC may determine that you require the services of a specialist. In referring you to another doctor, Calhoon Orthopaedic Rehabilitation & Exercise LLC may share or transfer your healthcare information to that doctor.

Payment Activities May Include:

- Activities undertaken by Calhoon Orthopaedic Rehabilitation & Exercise LLC to obtain reimbursement for services provided to you.
- Determining your eligibility for benefits or health insurance coverage.
- Managing claims and contacting your insurance company regarding payment.
- Collecting activities to obtain payment for services provided to you.
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges.
- Obtaining pre-certification and re-authorization of services to be provided to you.

For example, Calhoon Orthopaedic Rehabilitation & Exercise LLC will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Calhoon Orthopaedic Rehabilitation & Exercise LLC may contact you, by phone, text, mail, or email to provide appointment reminders. You may notify us if you do not wish to receive appointment reminders.

Calhoon Orthopaedic Rehabilitation & Exercise LLC may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.



CALHOON ORTHOPAEDIC REHABILITATION & EXERCISE

There are additional situations when Calhoon Orthopaedic Rehabilitation & Exercise LLC is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

As permitted or required by law.

- In certain circumstances, we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence, or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement officials for the purpose of reporting an apparent crime on our premises.

For public health activities.

- We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authorities authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

For health oversight activities.

- We may disclose health records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring, and evaluation and facility or individual licensure of certification. HIV test results may not be released to federal or state government agencies without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

Judicial and administrative proceedings.

- Patient healthcare records, including treatment records and HIV results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records, except for HIV results.

For activities related to death.

- We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigation for a death. HIV test results may be disclosed under certain circumstances.

For research.

- Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

To avoid a serious threat to health or safety.

- We may report a patient's name and other relevant data to the Department of Transportation, if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

For worker's compensation.

- We may disclose your health information to the extent such records are reasonably related to any injury for which worker's compensation is claimed.

For business associates.

- We may disclose your health information to other entities that provide a service to Calhoon Orthopaedic Rehabilitation & Exercise LLC that requires the release of your health information, but only if we have received satisfactory assurance that the other entity will also protect your health information.

Calhoon Orthopaedic Rehabilitation & Exercise LLC will not make any other use of disclosure of your protected health information without your written authorization. Calhoon Orthopaedic Rehabilitation & Exercise LLC will not use your health information to contact you for marketing purposes or sell your health information without your written consent. You may revoke such authorization at any time, except to the extent that Calhoon Orthopaedic Rehabilitation & Exercise LLC has taken action in reliance thereon. Any revocation must be in writing.



CALHOON ORTHOPAEDIC REHABILITATION & EXERCISE

Acknowledgment of Receipt of Notice of Privacy Practices I acknowledge that I have received a copy of Calhoon Orthopaedic Rehabilitation & Exercise LLC's Notice of Privacy Practices. This notice describes how Calhoon Orthopaedic Rehabilitation & Exercise LLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights I may have regarding my protected health information. I am aware and agree that Calhoon Orthopaedic Rehabilitation & Exercise LLC may use or disclose my health information for research purposes, under certain limited circumstances, and that, in the event my medical records are requested by a third party, I, or my appointed legal guardian, must sign a medical release form in order to distribute that information.

By signing below, I am acknowledging that I have read, understand, and agree to the **Release of Information, Insurance Notification, and the Notice of Privacy Practices.**

Patient/Guardian Signature _____ Print Name _____ Date _____



CALHOON ORTHOPAEDIC REHABILITATION & EXERCISE

Your Rights Regarding Your Protected Health Information (HIPPA)

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Calhoon Orthopaedic Rehabilitation & Exercise LLC to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restrictions, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to restrict disclosure of your health information to a health plan if you choose to pay out of pocket in full for the services at the time they are provided.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Calhoon Orthopaedic Rehabilitation & Exercise LLC may deny access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Calhoon Orthopaedic Rehabilitation & Exercise LLC send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Calhoon Orthopaedic Rehabilitation & Exercise LLC not send information to a particular address or location or contact you at specific locations, such as your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to be notified if your unsecured health information is breached.

You have the right to request that Calhoon Orthopaedic Rehabilitation & Exercise LLC amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing and under certain circumstances, the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Calhoon Orthopaedic Rehabilitation & Exercise LLC for the six years prior to the date of the request. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request to receive a paper copy of the notice, if you have previously received or agreed to receive the notice electronically.

Any person or patient may file a complaint with Calhoon Orthopaedic Rehabilitation & Exercise LLC and/or the Secretary of Health and Human Services if they believe their rights have been violated. To file a complaint with Calhoon Orthopaedic Rehabilitation & Exercise LLC, please contact the Privacy Office at the following: Privacy Officer: c/o Calhoon Orthopaedic Rehabilitation & Exercise LLC, 615 E 82nd Ave, Suite B1, Anchorage, AK 99518, 907-931-6927 (p).

It is the policy of Calhoon Orthopaedic Rehabilitation & Exercise LLC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspect or actual non-compliance or violation of the privacy standards.

Patient/Guardian Signature _____ Print Name _____ Date _____