Notice of Privacy Practices

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.

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1) Uses and Disclosures

We will use your protected health information (PHI) for the purposes of treatment, payment, and health care operations.

Treatment: Includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, and other physical therapists. For example: If we believe that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address swallowing difficulty, the health information we share with that provider would be considered a treatment-related disclosure.

Payment: Includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may request to review your medical record to determine that your care was necessary.

Health Care Operations: Includes the use of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses
Our practice may use your PHI to:

- Send you an appointment reminder
- Inform you of our other health-related products and services
- Request a contribution to our charitable activities

Uses and Disclosures Required by Law: The federal health information privacy regulations may permit or require us to use or disclose your PHI in the following ways:

- Share some of your PHI with a family member or friend involved in your care if you do not object
- Use your PHI in an emergency when you may not be able to express yourself
- Use or disclose your PHI for research purposes if provided with specific assurances that your privacy will be protected
- Disclose your PHI when required by law (e.g., court order or subpoena)
- Report certain diseases or adverse drug reactions to health oversight agencies

We may also use and disclose health information about you to:

- Avert a serious threat to your health or safety, or that of the public or others
- Release information to the Armed Forces if necessary for military command authorities
- Release information for workers' compensation or similar programs that provide benefits for work-related injuries or illnesses

Authorization: Your authorization is required before your PHI may be used or disclosed by us for purposes other than those described above.

2) Your Privacy Rights

Restrictions
You have the right to request restrictions on how your PHI is used. We are not required to agree, but if we do, we must abide by your request.

Confidential Communications
You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI
You have the right to request a copy of your medical record in writing. We may charge a fee to cover copying and mailing costs.

Amendments
You have the right to request that an amendment be made to your PHI if you disagree with what it says about you. This request must be in writing. If we disagree, we are not required to make the change. You do have the right to submit a written statement of disagreement, which will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures
You have the right to request an accounting of disclosures made in the previous six years. These will not include disclosures made for treatment, payment, or health care operations, or disclosures for which we have obtained your authorization.

Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should include enough specific information for us to investigate and respond. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this Notice of Privacy Practices. We reserve the right to update this notice if required by law. If updated, you will receive a revised notice when you next seek treatment from us.

Privacy Contact

If you would like more information about our privacy practices or to file a complaint, please contact:

Name: Amy Wunsch, MSPT
Title: Privacy Officer
Address: 23206 Lyons Ave, Suite 105, Santa Clarita, CA 91321
Phone: 661-383-9828

I have read and understand Next Level Physical Therapy's Privacy Practices

Patient or Guardian Signature _____

Printed Name _____

Date_____

Financial Policy

Thank you for choosing Next Level Physical Therapy and Athletic Performance as your health care provider. We are sincerely committed to providing you with a successful and pleasurable treatment experience.

Please understand that payment of your bill is considered part of your treatment and that this financial policy obligates you to provide full payment of your bill. All patients are required to establish financial arrangements for payment of their account and complete all provided forms before they are treated by our staff. As a courtesy, we will verify your insurance coverage and bill your insurance provider on your behalf. However, please understand that your insurance policy is a contract between you and your insurance provider.

Patient Financial Responsibility: I understand and agree that I am financially responsible for all charges for services provided by Next Level Physical Therapy and Athletic Performance, regardless of my insurance coverage. If my insurance company denies payment for any reason — including, but not limited to, administrative errors, eligibility disputes, benefit limitations, policy exclusions, or conflicting care records — I agree to pay all outstanding balances in full. This includes situations where services are denied due to incorrect information in my insurance records or other circumstances beyond the clinic's control. **You are responsible for any outstanding balances that are not covered by your insurance provider.**

INITIAL: _____

Patient Insurance: We require your co-payment and/or deductible payment at the time of treatment. In the event that your insurance changes to a plan in which Next Level Physical Therapy and Athletic Performance is not a participating provider, you will be responsible for the full amount that is billed for your services. Next Level Physical Therapy and Athletic Performance will not become involved in any disputes between you and your insurance provider regarding deductibles, co-payments, covered charges, "usual and customary" charges other than to supply factual information as requested. Many plans limit the number of visits you may receive per calendar year. This information is provided to you only as a summary of benefits and is not a waiver of your payment guarantee or an explanation of your benefits. Patients must contact their insurance company for full "disclosure" of benefits.

If you receive payment from your insurance provider for services rendered by Next Level Physical Therapy and Athletic Performance, you are required to reimburse Next Level Physical Therapy and Athletic Performance the full payment amount at the time of receipt. If you default on any balance owed to Next Level Physical Therapy and Athletic Performance and it becomes necessary for Next Level Physical Therapy and Athletic Performance to engage the services of an attorney, collection agency or other lawful method of collection, you will be responsible for the original balance owed and reimburse Next Level Physical Therapy and Athletic Performance for all costs incurred by it in the collection of said debt.

I am allowing a photocopy of my signature to be used for insurance purposes. I also authorize my insurance company to pay directly to Next Level Physical Therapy and Athletic Performance the amount due me in my pending claim for insurance.

INITIAL: _____

Missed Appointments: It is our mission to serve as many people as we can to have the greatest impact on our community. We understand that things happen that may result in the need to cancel an appointment. If you cannot make your appointment, please call us as soon as possible, so we may offer that appointment time to someone else who needs it. Please understand we reserve the right to charge $60.00 for any missed appointments that are not cancelled at least 24 hours in advance and this fee will become the responsibility of the patient and not billed to your insurance provider.

INITIAL: _____

Late Fee: A $15.00 per month late fee is assessed on all unpaid patient responsibility balances that are greater than 30 days.

Minors: The parent or guardian accompanying a minor is responsible for payment.

Auto Insurance: We will submit claims to your MedPay with your auto insurance. If you do not have MedPay, we will submit claims to your health insurance. Next Level Physical Therapy and Athletic Performance does not accept letters of protection.

Consent to Treat and Authorization to Release Information: I hereby authorize Next Level Physical Therapy and Athletic Performance, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and physical therapist in the treatment of my condition. I further authorize Next Level Physical Therapy and Athletic Performance to furnish and/or disclose my personally identifiable health information to the appropriate agencies for the purpose of billing.

I have had the opportunity to review the Next Level Physical Therapy and Athletic Performance Privacy Notice prior to signing this consent. I understand that I have the right to request restrictions on the uses and disclosures of my protected health information for treatment, payment and healthcare operations, but Next Level Physical Therapy and Athletic Performance is not required to agree to such a request. If Next Level Physical Therapy and Athletic Performance does agree to my request, the restrictions will be binding.

I have read the above Financial Policy and agree that I am responsible for the balance of my account for any professional services rendered by Next Level Physical Therapy and Athletic Performance.

Patient or Guardian Signature _____

Printed Name _____

Date_____