HIPAA Notice of Privacy Practices – Flaming Physical Therapy

11 Elsinore Avenue, Bath, Maine 207-442-9810
68 Chapman Street, Damariscotta, Maine 207-563-7990

Flaming Physical Therapy (FPT) pledges to maintain the privacy and confidentiality of our patients at all times. The full written privacy policy is available upon request. Any complaints regarding privacy issues should be addressed with the management at Flaming Physical Therapy.

All employees at FPT pledge to keep your health information confidential; however, your conversations may, at times, be overheard by other parties. You may meet with your Therapist of other staff members in a private room if this is a concern.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

In accordance with government guidelines, we are herein asking for your consent in sharing necessary information about your care at FPT with other parties including but not limited to your Physician, Health Insurance Carrier, Lawyer, or Case Manager. Necessary information may include but is not limited to the following areas: For Treatment, For Payment of Services, For health Care Operations, Judicial and Administrative Proceedings, to avoid a serious threat to health or safety, Health Oversight Activities, Law Enforcement, and Worker's Compensation.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding protected health information that we may obtain from you. You have the Right to inspect and copy any protected health information that may be used to make decisions about your care. You have the right to amend or supplement health information, if you feel that it is incorrect or incomplete. You have the right to request an "accounting of disclosures". You have the right to request restrictions or limitations on information we use or disclose about you. You have the right to a paper copy of this notice.

FLAMING PHYSICAL THERAPY IS ASKING FOR YOUR SPECIFIC DIRECTIVES IN THE FOLLOWING AREAS

Please initial <u>ONE</u> of the following options:

____ FPT has my consent to share necessary information regarding my Physical Therapy care as needed in accordance with the HIPAA Privacy Act.

____ FPT has my consent to share health information with ONLY THE FOLLOWING PARTIES:

In order to comply with federal regulations, we ask for your consent regarding TELEPHONE MESSAGES.

____ I authorize a telephone message may be left with any person or machine answering a phone call intended for me.

____ Telephone messages may be left ONLY WITH THE FOLLOWING: _____

I have read and understand the FPT privacy policy and consent to the sharing of necessary information about my care between appropriate parties in accordance with the HIPAA Privacy Act unless directed otherwise.

PATIENT (or GUARDIAN) Signature: _____ DATE:_____

PRINTED PATIENT NAME AND BIRTH DATE _____ DOB: ___/___/_____

PRINTED PARENT OR GUARDIAN NAME _____ DATE: _____