Bel Air
Gold Medal Building
407 E. Churchville Road
Suite 102
Bel Air, MD 21014
Phone: 410-638-5525
Fax: 410-638-5558

Perry Hall
Baltimore County Credit Union Bldg.
8640 Ridgely's Choice Drive
Suite L-1
Perry Hall, MD 21236
Phone: 410-529-0989
Fax: 410-529-0993

PRACTICE POLICY

Welcome to Gold Medal Physical Therapy, LLC

We have found that communication with our patients regarding our policies assists us in providing the best service to you. Please take the time to carefully read and sign our Practice Policy.

Our office is happy to cooperate with patients covered by insurance; however, you are responsible for knowing your insurance plan and benefits. Your insurance coverage is a contract between you and the insurance company, not a contract between our office and your insurance company. Our office will assist you with your insurance claim; however, regardless of your insurance coverage, responsibility ultimately falls on you, the patient, to make sure claims are paid accordingly.

SCHEDULING: We will make every effort to schedule an appointment at the most convenient day and time for you. Please give 24 hours advance notice if unable to keep a scheduled appointment so that we may use that time for another patient. *Cancelled appointments without advanced notice and missed appointments* will be subject to charge of $50 per appointment. If you need to change an appointment, we will make every effort to accommodate your busy schedule. We suggest that you schedule your appointments for eight weeks/or per plan of care. This will allow us to schedule at the times most convenient for you. After the third cancellation *or missed appointment* our office will determine if you need a consultation with the Therapist, need to move care to the Medically Oriented Gym (MOG), or be referred back to your physician.

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CO-PAYS: All co-pays are due at time of visit unless prior arrangements have been made. Please be advised of your Physical Therapy benefits prior to your first visit. It is your responsibility to know your insurance policy coverage.

OUTSTANDING BALANCES: Please be advised, interest of 1.5% per month will be applied to any outstanding balances over 60 days in duration.

PRESCRIPTIONS: Depending on your insurance policy, you may need a valid prescription from a Maryland State Licensed Physician, or a special referral from your primary care physician for physical therapy. It is the patient's responsibility to ensure the prescription is up to date and valid.

MEDICARE: Medicare patients need to be aware of the prescription requirements of their insurance. According to Medicare guidelines for physical and occupational therapy, prescriptions for therapy expire after 30 days.

INSURANCE: We are happy to bill your insurance company as a courtesy and convenience if we are provided with appropriate billing information. If we do not receive proper information, payment may be required at the time services are rendered. **PLEASE NOTE: it is your responsibility to know your insurance policy coverage in regards to physical therapy services.** In the event your insurance company forwards payment for physical therapy services to you, you will be responsible to deliver such payment to Gold Medal Physical Therapy, LLC.

NO INSURANCE: We are happy to provide services to patients not participating in a health insurance program, but we must ask that payment be made at the time services are rendered.

MEDICAL SUPPLIES: The patient will be responsible for the cost of any durable or medical goods supplied by Gold Medal Physical Therapy, LLC in the event that the insurance carrier does not cover these expenses.

AGREEMENT/AUTHORIZATION

A patient's medical records are considered private and confidential, and we value our patient's privacy. However, it may be necessary to provide copies of a patient's chart to insurance companies and/or an attorney to settle a dispute or facilitate payment. In order for us to provide this information, we must have your authorization. Without authorization, your account may remain unpaid and we may bill you directly for continued unpaid balances. Therefore, your signature below indicates your authorization for all uses required to obtain payment on your account.

I understand and agree that I am financially responsible and liable for payment for all charges assessed to me for professional services rendered by Gold Medal Physical Therapy, LLC. I understand that I am ultimately responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment for physical therapy services to me, I will deliver such payment to Gold Medal Physical Therapy, LLC immediately.

I understand and agree that if it becomes necessary for Gold Medal Physical Therapy, LLC to commence any legal action or obtain an attorney for collection of any outstanding charges on my account, I will be responsible for all reasonable fees incurred by Gold Medal Physical Therapy, LLC, in addition to such balance.

**A copy of our Notice of Privacy Practices and Practice Policies can be found on our website www.goldmedalpt.com

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HIPAA Omnibus Notice of Privacy Practices

Revised 2018

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, referring physicians, family practitioner, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

Our right to revise privacy practices: As permitted by aw, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policies and practices will be applied to all protected health information that we maintain and will be available at our facility for your request.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to

support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, and training of medical students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes

as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

You have the right to receive notice of a breach

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Teresa Jaccard	410-638-5525	tjaccard@goldmedalpt.com
HIPAA Compliance Officer	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.