Advanced Scoliosis Care

Physical Therapy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____ acknowledge that I have received a copy of the Advanced Scoliosis Care Notice of Privacy Practices. This Notice describes how Advanced Scoliosis Care may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and the rights I may have regarding my protected health information. I was also provided the right to request communication with Advanced Scoliosis Care be made by alternative means, such as sending information to my office rather than my home.

I wish to be contacted in the following manner (check all that apply):

___ Home Telephone:_____
___O.K. to leave message with detailed information
___O.K. to leave message for appointment reminders
___ Leave message with call-back number only

___ Cellular Telephone:_____
___O.K. to leave message with detailed information
___O.K. to leave message for appointment reminders
___ Leave message with call-back number only

___Written Communication
___O.K. to mail to my home
___O.K. to mail to my office
___O.K. to fax to my ___ Home
___ Office
___O.K to email me at my home email address _____
___O.K to email me at my office email address_____

___ Work Telephone
___O.K. to leave message with detailed information
___ Leave message with call-back number only

Patient Signature _____ Date _____

Personal Representative/ Guardian_____

Relationship to Patient_____

Advanced Scoliosis Care

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW Advanced Scoliosis Care. MAY USE AND DISCLOSE YOUR PROTECTED HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

Advanced Scoliosis Care 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 Advanced Scoliosis Care or received by Advanced Scoliosis Care from other healthcare providers.

We are required to provide you with 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. Advanced Scoliosis Care 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. Advanced Scoliosis Care 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 and Disclosures of Your Protected Health Information Not Requiring Your Consent

Advanced Scoliosis Care 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 the 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

For example, Advanced Scoliosis Care may determine that you require the service of a specialist. In referring you to another doctor, Advanced Scoliosis Care may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Determining your eligibility for benefits or health insurance coverage if we are an in-network provider
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under health plan, appropriateness of care, or justification of charges;

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinic guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Advanced Scoliosis Care may use your diagnosis, treatment, and outcome to measure the quality of the services provided, or assess the effectiveness of your treatment when compared to patients in similar situations.

Advanced Scoliosis Care may contact you by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written consent. 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.

There are additional situations when Advanced Scoliosis Care is permitted or required to use your protected health information without your 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 wounds to law enforcement officials if there is a reasonable cause to believe that the wound occurred as a result of a crime.

Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

• For public health activities.

We may release healthcare records, with exception of treatment records, to certain government agencies or public health authority 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.

This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecuting of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or the community from imminent and substantial danger.

- For health oversight activities we may disclose healthcare records, including treatment records, in response to a written request by a 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 or certification. HIV test results may not be released to federal or state governmental 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 test 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 test results.

  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 investigating 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 workers compensation.

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

Advanced Scoliosis Care will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Advanced Scoliosis Care has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information.

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Advanced Scoliosis Care 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, however if we do agree, we must adhere to the restriction, 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 only apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information complied for use (or in the anticipation for use) in a civil, criminal, or administrative action or proceeding. Advanced Scoliosis Care may deny any 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 Advanced Scoliosis Care send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Advanced Scoliosis Care not send information to a particular address or location, or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Advanced Scoliosis Care 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 disclosure of your protected healthcare records, made by Advanced Scoliosis Care 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 and receive a paper copy of this Notice, if you had previously received or agreed to receive this notice electronically. Any person or patient may file a complaint with the Advanced Scoliosis Care and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated.

Advanced Scoliosis Care

Consent for Treatment

Thank you for choosing Advanced Scoliosis Care for your Physical Therapy needs

We are a physical therapy clinic specializing in the conservative treatment of scoliosis and kyphosis for adolescents and adults. Our treatment method provides Schroth based scoliosis specific exercise training with advanced concepts further developed by Dr. Manuel Rigo of the Barcelona Scoliosis Physical Therapy School (BSPTS). The BSPTS is a recognized provider of conservative scoliosis treatment by the international Society of Scoliosis Orthopedic Rehabilitation and Research (SOSORT).

All physical therapy treatments are directed by an advanced certified Schroth Physical Therapist and provided on an individual basis. Your therapist will review your x-ray with you and/or your child and perform a thorough clinical assessment. An individualized, curve specific exercise program will be developed and you will be provided with a binder with photos and written instructions to facilitate carryover of the corrections and success with your program. Other traditional physical therapy treatments may be used as needed to address pain and neural tension.

The Schroth Method was developed for conservative management of idiopathic scoliosis of curves ranging from 15-55 degrees. It is at times used with larger curves when preparing for surgery or if the patient is not a surgical candidate. Coordination of care with an Orthopedic Surgeon in these cases is required to provide the best care to our patients.

The State of Texas Physical Therapy Board requires a written referral for physical therapy from one of the following: MD, DO, DC, DDS, DPM, ANP or PA. You will need to obtain a referral for services along with a full spine x-ray for scoliosis and sagittal (side view) films for kyphosis.

Attendance

It is our intention at Advanced Scoliosis Care to provide all of our clients with the best possible service. In fairness to our clients, we ask that you contact us within 24 hours of a cancellation so that we may accommodate other client's needs for scheduling. Repeat cancellations without this notice and habitual tardiness may result in discharge from services.

I acknowledge that I have received and agree with the policies outlined in this notice and I agree to the procedure or course of treatment that will be provided and discussed with me by a physical therapist. I also understand results of treatment cannot be guaranteed.

Patient Signature _____ Date _____

Guardian/Parent _____ Date _____

Advanced Scoliosis Care

Physical Therapy Health History

What is the patient's occupation or if adolescent what grade is the patient in? _____

What are the patient's hobbies/sports/ activities?

_____

_____

Please describe the problem that brought you to physical therapy:

_____

_____

When did you first notice the problem?

_____

Was the problem associated with any particular activity? [ ] Yes [ ] No If so describe:

_____

_____

When were you first diagnosed with scoliosis?

_____

What were the cobb angles at the time of diagnosis?

_____

What treatment was recommended by your physician?

_____

Were tests or other procedures used in diagnosing this problem? [ ] Yes [ ] No

If so please check and give approximate dates: [ ] MRI, Date _____ [ ] X-Ray, Date _____ [ ] CT scan, Date _____ [ ]

Other (please specify) _____ Date _____

Personal medical history: [ ] Diabetes [ ] Cancer [ ] Tobacco [ ] Pacemaker [ ] High Blood Pressure [ ] Cardiac [ ]

Marfans Syndrome [ ] Pregnancy (current/possible) [ ] Trauma to the Spine [ ] Connective Tissue Disorder

Do you have allergies? [ ] Yes [ ] No

If so please list:

_____

_____

Have you had surgery in the last 5 years? [ ] Yes [ ] No

If so describe:

_____

_____

Have you had prior treatment (physical therapy, chiropractic care, bracing, other)? [ ] Yes [ ] No If so describe:

_____

_____

What is the family history of your problem, and what was the treatment received?

_____

_____

If pain or other symptoms are present, please fill out the following questions.

Please rate pain intensity below:

At rest: 1 2 3 4 5 6 7 8 9 10 Activity: 1 2 3 4 5 6 7 8 9 10

What, if anything, makes your pain better or worse?

_____

_____

What is the frequency of your pain: [ ] Constant [ ] Present daily but not constant [ ] Present _____days/week

Please describe the pain:

_____

_____

_____

Other symptoms: [ ] Numbness [ ] Tingling [ ] Weakness [ ] Stiffness [ ] Grinding [ ] Popping

Patient Signature _____ Date _____

Guardian/Parent _____ Date _____

Advanced Scoliosis Care

PATIENT CONSENT
FOR PHOTOGRAPHS, AUDIOTAPING AND/OR VIDEOTAPING FOR DIAGNOSIS, TREATMENT, EDUCATION, OR MARKETING PURPOSES

Patient's Name_____ DOB_____

Address_____

Phone_____

I hereby give my consent to have photographs, videotaped images, and/or audio recordings to be made of my family member or myself for the following purposes:

Please check appropriate line:

_____ To support documentation of my medical condition.

_____ To record diagnostic or therapeutic procedure(s).

_____ For marketing or publicity purposes. Event: _____

_____ Educational purposes _____

_____Other _____

Unless otherwise required by state law or beyond the purposes of treatment and healthcare operations, photographs, videotapes, other images and audio recordings will not be released to outside requestors without specific authorization from the patient/legal representative.

_____

Signature of Patient or Legal Representative/Relationship Date signed

_____

Witness to signature Date signed

Advanced Scoliosis Care

Payment Agreement

Advanced Scoliosis Care is an in-network provider for Blue Essentials HMO, Blue Choice PPO and traditional Medicare. Patients covered by one of these policies will be subject to copays and or deductibles prior to services being rendered and Advanced Scoliosis Care will file claims on their behalf. All other patients are subject to fee for service care and payment is due at the time of service. An invoice will be provided to you to file for reimbursement from your insurance company as we cannot file claims on your behalf. All patients are encouraged to check your out of network benefits prior to scheduling your initial appointment to fully understand the cost of treatment.

I understand that I am responsible for all charges for services provided for me, regardless of insurance coverage, and that payment is due at the time services are rendered.

_____ Signature of Patient / Guardian

_____ Date