Privacy Notice

Your Information, Your Rights, Our Responsibilities

BeneFIT Physical Therapy
Bridgewater NJ 908.203.5200
Chester NJ 908.879.5700
BeneFITpt.com

Patient Name: Last:_____ First:_____

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.*

Your Rights
You have the Right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Receive copy of this policy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated.

Our uses and Disclosures
We may use and share your information as we:
- Treat you
- Bill for your services
- Run our organization
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with medical examiner/funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions.

Your Choices
You have some choices in the way that we use and share your information:

Consent to Release Information:
I am hereby giving my consent to BeneFIT Physical Therapy LLC and their office staff that they may disclose certain health information in the following manner (Mark all that apply):

Mobile Telephone Number:
☐ Ok to leave messages with detailed information
☐ Ok to leave text messages with detailed information
☐ Leave message with call back number only

Work Telephone Number:_____
☐ Ok to leave message with detailed information
☐ Leave message with call back number only

Written Communication:
☐ Ok to email to my email address

Designation of Certain Relatives, Close Friends, and Other Caregivers:
In addition to myself and my emergency contact I authorize BeneFIT Physical Therapy LLC to disclose certain health information to a family member, close personal friend, or other caregiver, since such person is involved with my health care or payment relating to my healthcare. In that case the practice will disclose information that is directly relevant to the person's involvement with my healthcare or payments.

I designate the person or people listed below are involved with my healthcare or payment relating to my healthcare for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at anytime in writing:

Print Name_____ Relationship: _____

Print Name_____ Relationship: _____

The following are **NOT AUTHORIZED** to receive my patient health information:

Print Name_____ Print Name_____

The Privacy Notice generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for, Patient Health Information to the minimum necessary to accomplish the intended purposes. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided above will constitute an adequate record. Uses and disclosures for treatment, payment, and healthcare operations may be permitted without prior consent.

I HAVE READ AND UNDERSTOOD THE ABOVE MATERIAL

Patient Signature: _____ **Date:** _____
(Parent or Guardian if Patient is a Minor)

HIPAA Notice of Privacy Practices

BeneFIT Physical Therapy
Bridgewater NJ 908.203.5200
Chester NJ 908.879.5700
BeneFITpt.com

This describes how medical information about you may be used or disclosed & how you can get access to this information. *Please review carefully.*

This Notice of Privacy Practices describes how we 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 PHI. "Protected health information" is information about, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your provider, 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 provider's practice, and any other use required by law.

Treatment: We will use and disclose your PHI 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 to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a course of physical therapy may require that your relevant PHI be disclosed to the health plan to obtain approval for the physical therapy treatment.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of physical therapy students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to physical therapy school students that see patients at our office. In addition, we may call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI 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 of Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and a copy of your PHI: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for purposes of TPO. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications 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: You may have the right to have your therapist amend your PHI. 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 we have, if any, of your PHI: We reserve the right to change the terms of this notice and will inform you any changes. You then have the right to object or withdraw as provided in the notice.

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 Administrator. We will not retaliate against you for filing a complaint.