TEMPOROMANDIBULAR DISORDERS
THE MCKENZIE APPROACH
ORTHOPEDIC & SPORTS
WORK HARDENING

COMPREHENSIVE REHABILITATION
PEDIATRIC REHABILITATION
PAIN MANAGEMENT
ARTHRITIS & HAND

DELAWARE VALLEY PHYSICAL THERAPY ASSOCIATES

AN INDEPENDENT MEDICARE CERTIFIED FACILITY. WE EMPHASIZE PATIENT EDUCATION
BODY MECHANICS, POSTURAL CORRECTION AND ERGONOMIC CHANGES.

DELAWARE VALLEY PHYSCIAL THERAPY ASSOCIATES NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Delaware Valley Physical Therapy Associates Legal Duty

Delaware Valley Physical Therapy Associates (DVPTA) uses your personal information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, DVPTA may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

DVPTA may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, DVPTA's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

DVPTA may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review your personal health information at any time. An administrative fee of $25.00 will be assessed for a copy of your records. You have the right to request that we correct any inaccurate or incomplete information to your records. Please make this request in writing. You also have the right to request a list of instances where we have disclosed your personal heath information for reasons other than treatment, payment or other related administrative purposes.

J.W. SCHORSCH, PT, DPT, CCTT
NJ License #40QA00537800
Certified Cervical & Temporomandibular Therapist (CCTT) by the Physical Therapy Board of Craniofacial & Cervical Therapeutics (PTBCCT)

J.S. MANNHEIMER, PT, PhD, CCTT
NJ License #40QA00083100
Certified Cervical & Temporomandibular Therapist (CCTT) by the Physical Therapy Board of Craniofacial & Cervical Therapeutics (PTBCCT)

R.T. KAUFFMAN, PT, MPT
NJ License #40QA00422900

C.J. GROVER, PT, MPT, Cert. M.D.T.
NJ License #40QA00621700
Certified in Mechanical Diagnosis & Therapy (MDT) by the McKenzie Institute

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PATIENT INFORMATION CONSENT FORM

IS THE INJURY FROM:
MOTOR VEHCHILE ACCIDENT? YES NO
AN ON THE JOB INJURY? YES NO
ARE YOU CURRENTLY WORKING? YES NO
DO YOU HAVE A FOLLOW-UP APPOINTMENT WITH REFERRING DOCTOR? _____

I have read and fully understand Delaware Valley Physical Therapy Associates (DVPTA) notice of information practices. I understand that DVPTA may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how me personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand DVPTA will consider requests for restrictions on a case by case basis, but does not have to agree to the request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in DVPTA's Notice of Information Practices, which included releasing any information necessary to process my insurance claim. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I understand that "Notice of Patient Information Practices" is available upon request.

I authorize payment of medical benefits directly to DVPTA for services rendered. My signature serves also as my assignment of benefits. Should enforcement be necessary to collect the bill, attorney (50%), and collection fees (30% - 50%) as well as interest charges (1 ½ % APR) will be my responsibility. I understand that all payment for services rendered are due in 45 days and I am responsible for all charges not processed by my insurance.

APPOINTMENTS ARE NOT SET AUTOMATICALLY
PLEASE SEE RECEPTIONIST TO SCHDEULE

I understand that co-pays are due upon arrival at each visit. Please be aware that our office does not wait for any cases that are pending litigation or are in suit. Its your responsibility to know your insurance benefits and limitations. If any changes to your plan you must notify our office. All referrals are your responsibility to obtain.

_____
Patient Name (Print)

_____ _____
Signature (Guardian, if minor) **Date**

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This will serve as authorization for Delaware Valley Physical Therapy to email me information regarding appointment confirmation, insurance denials, authorizations and any information that would be necessary to submit your claims.

This authorization will remain in force until you notify us in writing.

PATIENTS NAME: _____

EMAIL ADDRESS: _____

DATE SIGNED: _____

www.delvalphysicaltherapy.com
123 FRANKLIN CORNER ROAD
SUITE 103
LAWRENCEVILLE, NJ 08648
PHONE NUMBER: 609-896-9054
FAX NUMBER: 609-896-9059
EMAIL: DVPTA123@GMAIL.COM

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DEAR PATIENT:

In a effort to provide you with flexible payment arrangements, we have expanded our payment policy.

Payment is requested at the time of your visit.
We now offer the following payment options:

_____Payment by CASH

_____Payment by CHECK

_____Payment by CREDIT CARD

We accept VISA, MASTERCARD & DISCOVER

PRINT NAME:_____

SIGNATURE:_____

Date Signed:_____

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

☐ Other _____

_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations; A=Authorization on File; D=Discretionary
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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Date: _____

Patients Name: _____

Patients Chart: _____

This is to advise you that your chart may go into medical review. Depending on the plan of benefits, the review may occur on the 10th or 25th visits.

This review could take up to 30 days for a decision to be made.

Your insurance company, Aetna, will determine if the services rendered will be medically necessary and reimbursable by Aetna. Please be aware that in some cases Aetna requires an additional deductible, co-insurance or co-pay for the initial evaluation (first visit) and the re-evaluation (which generally occurs once a month). If you have any additional questions regarding your policy contact Aetna directly.

You will be responsible for any services not covered by your insurance company.

Sincerely,

Marlene M. Ricevuto
Medical Records

Patient Signature/Guardian: _____

Date:_____

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