PHYSICAL THERAPY PLUS PATIENT DATA SHEET

DO NOT EMAIL The electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

_____

_____

_____

_____

Mailing Address:

_____

_____

_____

Phone Numbers:	**OK To Call**	**Best Time To Call**
Home: _____	☐	_____
Work: _____	☐	_____
Cell: _____	☐	_____

May we send you text messages for your appointment reminders to the number(s) listed above? By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

☐ Yes ☐ No

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: _____

Preferred language: _____ **Interpreter required?** ☐ Yes

Date of Injury: _____ **Referring Physician:** _____

Injury Area: _____ **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other _____

Specify if other : _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Patient **Date**

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:
PHYSICAL THERAPY PLUS
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:**_____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
Initials:_____

LIABILITY

I know and agree that: PHYSICAL THERAPY PLUS is not responsible for loss or damage to personal valuables.
Initials:_____

WAIVER AND RELEASE

I hereby release, discharge and acquit: PHYSICAL THERAPY PLUS its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care service.
Initials:_____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to PHYSICAL THERAPY PLUS
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices.
Initials:_____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials:_____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:**_____
I acknowledge receipt of the Statement of Patient Rights. **Initials:**_____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature_____ Witness Signature _____

PHYSICAL THERAPY PLUS MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? YES NO
CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_____
AND WHY_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:
_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____
_____

ALLERGIES: Medication _____Reaction_____ Other _____Reaction_____
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ CANCER
- ☐ CARDIOVASCULAR PROBLEMS
- ☐ HOLTER MONITOR - currently wearing?
  - ☐ PACEMAKER
  - ☐ HIGH BLOOD PRESSURE ☐ controlled ☐ uncontrolled
- ☐ LOW BLOOD PRESSURE
- ☐ CURRENTLY PREGNANT
- ☐ DIABETES ☐controlled ☐uncontrolled
- ☐ DEPRESSION
- ☐ DIZZINESS/FAINTING
- ☐ FRACTURES
- ☐ HEADACHES
- ☐ HEPATITIS/HIV
- ☐ KIDNEY PROBLEMS
- ☐ MRSA (Methicillin Resistant Staphylococcus Aureus)
- ☐ OSTEOPOROSIS
- ☐ RESPIRATORY PROBLEMS
  - ☐ ASTHMA ☐ controlled ☐ uncontrolled
  - ☐ COPD ☐ controlled ☐ uncontrolled
  - ☐ Other
- ☐ SEIZURES ☐ controlled ☐ uncontrolled
- ☐ THYROID PROBLEMS
- ☐ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: _____

☐ ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____Date_____

CONSENT TO USE OF LIKENESS AND TESTIMONIAL AND RELEASE

I, _____, hereby consent to PHYSICAL THERAPY PLUS allow and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("marketing materials") in Clinic's marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

_____ _____

Participant Name Date

_____

Parent/Legal Guardian (If Participant is a Minor)

HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

I, _____, hereby consent and PHYSICAL THERAPY PLUS and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

_____

Date

_____

Participant Name

_____

Parent/Legal Guardian (If Participant is a Minor)

PHYSICAL THERAPY plus
A PROGRESSIVE APPROACH TO REHABILITATION

NOTICE OF PRIVACY PRACTICES

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.

UNDERSTANDING YOUR HEALTH RECORD

A record is made each time you are treated at our Clinic. Your injuries, evaluation and test results, diagnosis, treatment, and a plan of care are recorded. This information is most often referred to as your "health or medical record," and it serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used and shared will help you to ensure its accuracy and enable you to understand who, what, when, where, and why others may be allowed access to your health information. This Clinic uses health information about you as described in this Notice. Your health information is contained in a medical record that is the physical property of our Clinic.

OUR RESPONSIBILITIES

This Clinic is required by law to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This Clinic is required to abide by the terms of this notice, as currently in effect, and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

REVISIONS

This Clinic reserves the right to change its practices and this Notice and effect the new provisions with respect to all health information that it maintains (including information that this Clinic had prior to implementation of the new provision). If we update this Notice, we will provide the revised Notice to you at your next appointment and post a copy of it on our website: ptplusnj.com. Other than for reasons described in this notice, this Clinic agrees not to use or disclose your health information without your authorization.

USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION

This Clinic may use and disclose your health information without your authorization in order to provide "Treatment," obtain "Payment," and perform our "Health Care Operations," as well as other specific reasons as detailed below:

- **Treatment** – We may use and disclose health information about you to provide you with products and services or related medical treatment or services. To this end, we may communicate with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, information related to your treatment may be shared with a health care provider, such as your physician, a pharmacist, nurse, or other person providing health services to you. This information is necessary for health care providers to determine what treatment you should receive. Health care providers also may record actions taken by them in the course of your treatment and note how you responded to the actions. We may also use your medical information to give you information about treatment options or other health-

related benefits and services that may interest you.

- **Payment** – We may use and disclose health information about you to others for purposes of receiving payment for treatment and services that you receive. For example, information regarding treatment you have received may be sent to you or someone who pays on your behalf (such as a family member or an insurance company) in order for this Clinic to receive payment. The information used in this fashion may include details regarding your services that identify you and could identify your diagnosis or treatment. Although it is unlikely, if other treatment providers need medical information about your treatment in order to bill for their services, we may provide it to them. We will comply with your request not to disclose your medical information to your insurance company if the information relates solely to a healthcare item or service for which you have paid out of pocket and in full to us.

- **Health Care Operations** – We may use and disclose health information about you for administrative and operational purposes. Risk management or quality improvement personnel may use health information about you to assess the care and outcomes in your case and others like it. The results will be used internally to continually improve the quality of care for all patients. For example, we may combine medical information about many patients to evaluate the need for new products, services, or treatments. We may disclose information to health care professionals, students, and other personnel for review and training purposes. We also may combine health information we have with other sources to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy and to allow others to use the information to study health care without learning the identity of the specific patients. We may also use and disclose your medical information to:
  - evaluate the performance of our staff and your satisfaction with our services;
  - learn how to improve our facilities and services;
  - determine how to continually improve the quality and effectiveness of the health care we provide; and
  - conduct training programs or review competence of health care professionals.

- **Individuals Involved in Your Care or Payment for Your Care** – We may release health information about you to a family member, guardian, or friend who is involved in your medical care. We also may give information about you to someone who helps pay for your care. If you have any objection to sharing your medical information in this way, please contact the Privacy Officer, whose contact information is listed at the end of this Notice.

- **You or Your Personal Representative** – We may disclose your medical information to you or to a representative appointed by you or designated by applicable law.

- **Disaster Relief** – In addition, we may disclose health information about you to an entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status, and location. We may also disclose medical information about you to local authorities or utility companies if your home care is considered "life-supporting" and you require immediate attention in the event of an emergency or power outage.

- **Business Associates** – We may share your medical information with outside companies that perform services for us, such as companies that receive phone calls from patients when our offices are closed and companies that store patient files for us. In addition, we also contract with accountants, consultants, and attorneys to provide us with services. These outside vendors are called "Business Associates" and they are required to safeguard your information by HIPAA and by contract.

- **Participation in Health Information Exchanges** – We may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, and permitted health care operations purposes with other participants in the HIE. Depending on state law requirements, you may be asked to "opt-in" in order to share your information with HIEs, or you may be provided the opportunity to "opt-out" of HIE participation. HIEs allow your health care providers to efficiently access your medical information that is necessary for treating you and other lawful purposes.

- **Reminders** – We may use health information about you to provide you with reminders about appointments.

- **Alternative Treatments and Health Benefits** – We may use health information about you to provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you.

- **Future Communications** – We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which we are participating.

- **Required by Law** – We may use and disclose health information about you as required by federal, state, or local law.

- **Public Health** – We may use or disclose health information about you for public health activities, such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability; reporting deaths; and reporting reactions to medications or problems with products.

- **Food and Drug Administration (FDA)** – We may use or disclose health information for purposes of notifying the FDA of adverse events with respect to medication and product defects or post marketing surveillance information to enable product recalls, repairs, or replacements.

- **Health and Safety** – We may use or disclose health information about you to avert a serious threat to the health or safety of you, the public, or any other person pursuant to applicable law.

- **Protective Services for the President and Others** – Your medical information may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

- **National Security and Intelligence Activities** – We may disclose your medical information to authorized federal officials for national security and intelligence activities authorized by law.

- **Military and Veterans** – If you are a member of the armed forces, your medical information may be released as required by military command authorities.

- **Medical Examiners and Others** – We may use or disclose health information about you to medical examiners, coroners, or funeral directors to allow them to perform their lawful duties.

- **Organ and Tissue Donation** – If you are an organ or tissue donor, we may use or disclose health information about you to organizations that help with organ, eye, and tissue donation and transplantation, or to an organ donation bank.

- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

- **Workers Compensation** – We may use or disclose health information about you to comply with laws and regulations related to workers compensation.

- **Research** – We may use or disclose health information about you for research purposes under certain circumstances. For example, we may disclose health information about you to a research organization if an institutional review board or privacy board has reviewed and approved the research proposal after establishing protocols to ensure the privacy of your health information. All research projects involving your medical information must be approved through a special review process to protect your confidentiality.

- **Information Not Personally Identifiable** – We may use or disclose health information that does not personally identify you or reveal who you are.

- **Law Enforcement** – We may disclose your health information to the police or other law enforcement officials as required or permitted under state law.

- **Health Oversight Activities** – We may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with rules of governmental health programs, such as Medicare or Medicaid. These oversight activities include, for example, audits, investigations, inspections, and licensure.

- **Victims of Abuse, Neglect or Domestic Violence** – If this Clinic reasonably believes you are a victim of abuse, neglect or domestic violence, we may disclose your health information to the appropriate governmental agency authorized by law to receive reports of such abuse, neglect or domestic violence.

- **Judicial and Administrative Proceedings** – This Clinic may disclose your health information in the course of a judicial proceeding in response to a legal order, subpoena, discovery request, or other lawful process.

USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WITH YOUR AUTHORIZATION

Other uses and disclosures not described in this Notice will be made only with the individual's written authorization. You may revoke (take back) an authorization that you had previously provided by giving us written notice. In that case, we will cease using or disclosing your information for the purpose that you had authorized. However, we are unable to retract or invalidate any uses or disclosures that were made with your permission before you revoked your authorization. *The following are some examples of uses or disclosures that require your authorization:*

- **Psychotherapy Notes** – We do not typically maintain psychotherapy notes on any of our patients. However, if we wanted to use or disclose any psychotherapy notes we had in our possession (for instance, as part of your medical record), we would have to ask for you authorization to do so, unless the use or disclosure was to undertake certain treatment, payment, or health care operation activities as described above.

- **Other Sensitive Information** – In addition, other types of information may have greater protection under federal or state law, such as certain drug and alcohol information, HIV/AIDS and other communicable disease information, genetic information, mental health information, or information about developmental disabilities. We do not generally maintain this type of information. But, if we do, we may be required to get your written permission before disclosing it to others, and we may seek that permission if permitted by law.

- **Marketing** – We must obtain your authorization before we use or disclose your health information for marketing purposes, unless that marketing relates to certain treatments you are already undergoing (or available alternatives), the marketing is conducted face-to-face, or the marketing involves a promotional gift of nominal value. If we receive any payment for the use of your information for marketing purposes, we will tell you so in the authorization that we ask you to sign.

- **Sale of Health Information** – This Clinic will not sell your health information. However, if we change this policy in the future, we will be required to seek your authorization before selling any of your health information.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights with respect to health information about you. To exercise any of your rights, please see the contact information at the end of this notice.

- **Right to Inspect and Copy** – You have the right to inspect and/or obtain a copy of the health information about you that we maintain in certain groups of records that are used to make decisions about your care. You have the right to an electronic copy of your health information if it is maintained electronically. Your request must be in writing. If you request a copy of your health information, we may charge you a fee to cover the costs of copying and mailing the information. If you request a copy of your information electronically on a portable electronic media device (such as a CD or USB drive), we may charge you for the cost of that media device. In certain very limited circumstances, we may deny your request to inspect and copy your health information. If you are denied access to your health information, we will explain our reasons in writing. You have the right to request that the decision be reviewed by another person. We will comply with the outcome of the review.

- **Right to Amend** – If you feel that health information about you that we maintain in certain groups of records is inaccurate or incomplete, you have the right to request that we amend the information. You have the right to request an amendment as long as we maintain the information. Your request must be in writing and include a reason supporting the request. In certain circumstances, we may deny your request to amend your health information. If your request for an amendment is denied, we will explain our reasons in writing. You have the right to submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you that we maintain in certain groups of records.

- **Right to an Accounting of Disclosures** – You have the right to request an accounting or detailed listing of certain disclosures of your health information. The accounting will not include all disclosures of your medical information. For example, you do not have the right to request an accounting of disclosures of your medical information made (1) for purposes of treatment, payment, and health care operations; (2) to you and pursuant to your authorization; or (3) for other purposes for which federal law does not require us to provide an accounting. The time period covered by the accounting is also limited to six years. Your request must be in writing. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

- **General Right to Request Restriction** – You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing. Please be aware that we are not required to agree to your request for restrictions. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse). If we agree to your request for a restriction, we will comply with it unless the information is needed for emergency treatment.

- **Right to Restrict Disclosure to a Health Plan** – You have the right to request that we not disclose the portion of your health information developed during a treatment that you (or someone else) paid for entirely out-of-pocket to your health plan. This request must be in writing. We may not refuse this request.

- **Right to Request Alternative Communications** – You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternative address for delivery or communication purposes.

- **Right to Revoke Authorization** – There are occasions when you may give us written authorization to use or disclose your health information. You have the right to revoke your authorization to use or disclose health information, except to the extent that action has been taken in reliance upon your authorization.

- **Right to be Notified of a Breach** – In the event some portion of your health information is lost, stolen, or otherwise improperly accessed, you have the right to be informed to the extent required under applicable law. You will be informed in writing, unless you have previously established a preference for electronic communications.

- **Right to Copy of Notice of Privacy Practices** – You have the right to a paper copy of our Notice of Privacy Practices at any time. To obtain a copy of our current Notice of Privacy Practices, please contact our Privacy Officer at the address and telephone number provided at the end of this notice. You may also obtain a copy of this notice from our website: ptplusnj.com. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

QUESTIONS AND COMPLAINTS

For additional information about this Notice or if you have a question, you may contact our Privacy Officer at (713) 344-0351. If you believe your privacy rights have been violated, you have the right to complain to this Clinic and to the Secretary of the U. S. Department of Health and Human Services. To submit a complaint to the Department of Health and Human Services, you may contact the Office for Civil Rights of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. Some states may allow you to file a complaint with state's Attorney General, Office of Consumer Affairs, or other state agency as specified by applicable state law. You may make a complaint with this Clinic via the contact information at the end of this notice. You will not be retaliated against for filing a complaint.

CONTACT INFORMATION

If you have any questions, wish to obtain copies of your health information, amend, request an accounting, or exercise any other rights identified in this notice, or would like to file or discuss a complaint regarding our privacy practices, please contact this Clinic's Privacy Officer by telephone at (713) 344-0351, by fax at (713) 430-4044, or by email at Compliance@usph.com.

Notice of Privacy Practices Availability: This notice will be posted where registration occurs. All individuals receiving care will be provided a hard copy upon request and asked to acknowledge receipt.