HealthWest THERAPY

1482 La Mirada Drive San Marcos, CA 92078

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for JG Performance Fitness, Inc., doing business as Healthwest Therapy, to furnish medical care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her physical condition.

_____ Responsible Party Initials

AUTHORIZATION BENEFIT ASSIGNMENT – FINANCIAL RESPONSIBILITY – RELEASE OF INFORMATION

I authorize Healthwest Therapy to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Healthwest Therapy from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between Healthwest Therapy and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that I will make payments on the date of service, unless other arrangements have been made and a separate financial payment contract exists between Healthwest Therapy and me.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize Healthwest Therapy to release all information necessary, including medical records, to secure payment.

_____ Responsible Party Initials

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the Healthwest Therapy Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Healthwest Therapy to use and disclose my protected health information to carry out treamtne, payment activities and health care operations. I understand the terms of this notice may change with time and Healthwest Therapy will always post the current notice at the clinic and have copies available for distribution.

Indicated below are individuals whom Healthwest Therapy may speak to regarding my treatment. Please list names.

Spouse _____ Father _____

Mother _____ Other _____

Listed below are individual(s) whom I request restriction regarding my protected health information.

Not Applicable

Other _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone number(s) you provide us?

Yes _____ Home Mobile Work Other _____

_____ Responsible Party Initials

SIGNATURE FOR CONSENT

By my signature below, I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent for Care nd Treatment, the Authorization to release all information necessary to secure payment and the Consent For Use and Disclosure of Health Information.

Patient/Guardian/Responsible Party Signature _____

Date _____

HealthWest THERAPY
1482 La Mirada Drive
San Marcos, CA 92078
(760)704-7000

CLINIC POLICIES

We strive to provide you the best, personalized care available. To make this possible, we adhere to a set of important guidelines. Please read them carefully, initial each point in the appropriate section, and indicate your agreement by signing on the bottom of this form.

- **Late Policy "10 minutes"** – Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient. _____
- **24-Hour Advance Notice Fee** – If you wish to change or cancel an appointment we require a minimum 24-hour advance notice. Anything less will result in a $20 fee charged to your account. Advance notice allows someone else time to reserve it in place of you. _____
- **Copays are Due upon Arrival** – If you happen to forget your wallet or checkbook, we may still be able to see you upon completion of an "Extension Request" form. This is a 'promise-to-pay' form and carries a minimal fee that allows you to keep your appointment. _____
- **No Show Policy** – If you fail to show for an appointment without notice, all future appointments may be removed and a $20 fee will apply to your account. If your appointments are removed from the schedule, you can reschedule them on a 'first come, first served basis.' _____
- **Cell Phones** – We realize emergencies may arise and therefore we allow you to carry your cell phone during your session, however, please be courteous and set it to silent mode or turn it off. _____
- **Children Requiring Supervision** – You may NOT bring any children who require supervision during your appointment. If your child does not require attention and can sit quietly, you may bring them. _____

I understand the policies heretofore of HealthWest Therapy and that such policies must be implemented so that my recovery is both successful and efficient.

_____ _____

Print your Name and Date Signature

HealthWest THERAPY

PATIENT INTAKE FORM

Name: (Dr. /Mr. /Mrs. /Ms.) _____ **Date:** ____/____/____
Address: _____ **Home Phone:** _____
City: _____ **State:** _____ **Zip:** _____ **Work Phone:** _____
Social Security Number: _____-____-_____ **Date of Birth:** ____/____/____
Person to be notified **in case of emergency** and phone#: _____
Referring Physician: _____ **Primary Physician:** _____

Have you had previous Physical Therapy within this calendar year? ___ YES ___ No
If Yes, WHEN, WHERE and for WHAT body part? _____
_____

Are you currently receiving any home health services? (i.e. nursing, therapy, lab tests) ___Yes ___ No

Party Responsible for Payment: ___ Self ___ Personal Insurance ___ Workers' Compensation
___ No Fault ___Other_____ _____

Insurance Information: (*please note that it is your responsibility to provide accurate insurance information*)
Primary: _____ Policy/Group#:_____
Secondary: _____Policy/Group#:_____

If Work-Related, please provide the following information:
Employer: _____ Occupation: _____
Address: _____ Currently Working: __ Yes __ No
Insurance Carrier: _____ Case Manager:_____
Phone Number: _____ WCB#: _____ Carrier Case #: _____

I understand that billing of insurance companies is a courtesy, and that I am financially responsible for payment at the time services are rendered. If I do not provide the correct information required for billing, I agree to be personally responsible for all expenses associated with services rendered. Expenses may include interest charges, collection fees, and legal/court costs. I hereby give permission to HealthWest Therapy to administer treatment for my condition and authorize them to release all necessary medical information to parties responsible for payment. I also understand that I may receive Physical Therapy without a prescription from my physician and that my insurance company may deny payment if a prescription is not provided.

Signature: _____ **Date:** _____

Our billing department will attempt to answer any questions regarding your financial responsibility; however, specific questions pertaining to your contract should be directed to your insurance carrier.

1482 La Mirada Drive
San Marcos, CA 92078
(619) 373-6100

NOTICE OF PRIVACY PRACTICE

JG PERFORMANCE FITNESS, INC., dba HEALTHWEST THERAPY'S Notice of Privacy Practices is effective April 1, 2015. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

The terms of this Notice of Privacy Practices apply to Healthwest Therapy and each of its subsidiaries, affiliates, and entities managed or controlled by Healthwest Therapy, including the corporate office and it's employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment and health care operations as permitted by law. Use or disclosure pursuant to this Notice may include electronic transmittal or disclosure of your personal health information.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of the Notice for as long as it remains in effect. We reserve the right to change the terms of the Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Healthwest Therapy. Should we make a change, you may obtain a revised copy from the location providing treatment. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer, Healthwest Therapy, 1482 La Mirada Drive, San Marcos, CA 92078.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

A. Uses and Disclosures That May Be Made Without Your Consent

a. *Uses and Disclosures for Treatment*: We may take uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in our medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

b. *Uses and Disclosures for Payment*: We may make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

c. *Uses and Disclosures for Health Care Operations*: We may use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

d. *Business Associates*: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons of organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

e. *Appointments and Services*: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate reasonable requests by you, to receive communications regarding your personal health information form us by alternative means or at alternative locations. For instance, if you wish for appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such requests. You may make your requests by sending your name and address to: Healthwest Therapy Privacy Officer, 1482 La Mirada Drive, San Marcos, CA 92078.

f. *Research:* In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

g. *Other Uses and Disclosures:* We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law,
- Public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations,
- If we suspect child abuse or neglect,
- If we believe you to be a victim of abuse, neglect, or domestic violence,
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls,
- To your employer when we have provided health care to you at the request of your employer,
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings,
- In response to a court or administrative ordered subpoena or discovery request,
- To law enforcement officials as required by law to report wounds and injuries and crimes,
- To coroners and/or funeral directors consistent with law,
- if necessary to arrange an organ or tissue donation for you or a transplant for you,
- if you are a member of the military we may also release your personal health information for national security or intelligence activities, and
- to workers' compensation agencies for workers' compensation benefit determination.

B. Uses and Disclosures That May Be Made Either With Your Authorization or the Opportunity to Object

a. *Individuals Involved In Your Care*: Unless you object, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other personal that may be involved in some aspect of caring for you.

C. Uses and Disclosures Based Upon Your Written Authorization

a. *Psychotherapy Notes*: We must obtain your written authorization for most uses and disclosures of psychotherapy notes.
b. *Marketing:* We must obtain your written authorization to use and disclose your personal health information for most marketing purposes.
c. *Sale of Personal Health Information*: We must obtain your written authorization for any disclosure of your personal health information which constitutes a sale of personal health information.
d. *Other Uses:* Other uses and disclosures of your personal health information, not described above, will be make only with your written authorization. You may revoke your authorization, at any time, in writing, except to the extent that we have taken action in reliance on the authorization.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

A. **Access to Your Personal Health Information –** You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. If you request a copy of your personal health information you may be charged a nominal fee for copying and postage.

B. **Amendments to Your Personal Health Information –** You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your legal representative, and must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office.

C. **Accounting for Disclosures of Your Personal Health Information –** You have the right to receive an accounting of certain disclosures made by us of your personal health information after May 1, 2015. Requests must be made in writing and signed by you or your legal representative. "Accounting Request

Forms" are available from the front office. The first accounting in any 12-month period is free. You will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

D. **Restrictions on Use and Disclosure of Your Personal Health Information -** You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. However, we must agree not to disclose your personal health information to your health plan if the disclosure is for payment or health care operations and relates to a health care item or service which you paid for in full out of pocket. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the even of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

E. **Receive Confidential Communications From Us by Alternative Means or at Alternative Locations –** You have the right to request that we communicate with you in a certain way or at a certain location. Your request must be in writing and specify how and where you would like to be contacted. We will accommodate all reasonable requests.

F. **Paper Copy –** You have the right to obtain a paper copy of this notice from us.

G. **Breaches of Unsecured Personal Health Information –** You have the right to be notified if you are affected by a breach of unsecured personal health information.

H. **Workers' Compensation –** For patients whose medical treatment is covered under a state workers' compensation program, please note the following: Disclosure of your protected health information (PHI) for purposes of providing treatment and obtaining payment under the state's workers' compensation is governed by the state workers' compensation regulations and procedures. Therefore, we are not obligated to secure a written authorization as otherwise required by HIPPA in order to disclose your PHI for workers' compensation purposes, nor may you restrict our use of disclosure of your PHI for workers' compensation purposes. Written consent to use or disclose your PHI may be required pursuant to our internal policies and/or state workers' compensation program rules in order to process your claims. Failure to provide any required written consent may result in your financial liability for medical services and supplies.

I. **Complaints –** If you believe your privacy rights have been violated, you can file a complaint in writing with the Priivacy Officer, Healthwest Therapy, 1482 La Mirada Drive, San Marcos, CA 92078. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

J. **For Further Information –** If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer, Healthwest Therapy, 1482 La Mirada Drive, San Marcos, CA 92078. Telephone – (619) 373-6100.