Stride Physical Therapy
70 Schanck Road, Unit East,
Freehold, NJ 07728
Ph: 203-927-6962

PRIVACY NOTICE

Your Information, Your Rights, Our Responsibilities

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:
ÅGet a copy of your paper or electronic medical record
ÅCorrect your paper or electronic medical record
ÅRequest confidential communication
ÅAsk us to limit the information we share
ÅGet a list of those with whom weôve shared your information
ÅGet a copy of this privacy notice
ÅChoose someone to act for you
ÅFile a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
ÅTell family and friends about your condition
ÅProvide disaster relief
ÅMarket our services

Our Uses and Disclosures
We may use and share your information as we:
ÅTreat you
ÅRun our organization
ÅBill for your services
ÅHelp with public health and safety issues
ÅDo research
ÅComply with the law
ÅRespond to organ and tissue donation requests
ÅWork with a medical examiner or funeral director
ÅAddress workersôcompensation, law enforcement, and other government requests
ÅRespond to lawsuits and legal actions

The undersigned has read this notice and has received a copy of this signed notice and the Notice of Privacy Practices, if requested.

Name_____Signature_____Date_____

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Financial Policies, Scheduling Policies and Authorizations – Front & Back

Patient Name: _____
(Last) (First) (M.I.)

Financial Responsibility & Credit/Debit Card Authorization: I have requested professional services from Stride Physical Therapy (ñProviderò) on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all copayments, coinsurances, and deductibles for said services are due and payable on the date services are rendered and agree to pay all such charges incurred at each visit, **unless an alternate payment plan** has been made in advance. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full.

If an explanation of benefits (EOB) from my insurance carrier demonstrates that an amount is due to this provider, I will pay them the amount due within 30 days of being invoiced. With the credit or debit card copy I have provided, I authorize the provider to charge my card for balances that I fail to pay within that 30 day period. If the insurance carrier fails to assign benefits to this provider and instead makes payment to the insured, and the checks are not signed over to the provider, this credit/debit card authorization extends to the amounts paid to the insured.

Payment Plans & Credit/Debit Card Authorization: Only a payment plan agreement can modify the amount of payments I must pay the provider and when they are due in the above section. If I have a payment plan agreement and I do not make my payments as they are due on each day of service, I authorize the provider to charge the credit/debit card I have provided for all outstanding payment plan balances.

Assignment of Insurance Benefits: I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for updating it.

I hereby authorize Provider to submit claims, on my and/or my dependentsô behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

Authorization to Release Information: I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Authorization to Provide Care & Use Personal Health Information: This patient (or their authorized signing representative) authorizes Provider to provide physical therapy care as it relates to their diagnosis and the patientôs prescription, if provided by a referring physician. I also authorize Provider to use my personal health information as necessary for their health care operations. I understand that I can revoke my authorization and/or restrict use of certain personal health information if I inform this office in writing.

ERISA Authorization:
I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

No-Show / Cancellation Policy

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patients scheduling needs and keeps the clinic operating at its most efficient level. Due to our one-on-one 60-minute treatments, missed appointments are a significant inconvenience to your treatment, the clinic and other patients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

2. We reserve your appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to place another patient in your cancelled appointment time, to receive needed treatment.

3. Certain accident claims adjusters expect regular attendance to therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. Your clinician will develop a specific plan of care based on your individual goals/outcomes and physical impairments. Adhering to this plan of care (frequency/duration) is crucial to your outcome.

5. At our discretion, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

_____initial here to acknowledge that you've read and fully understand this policy

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Signature:_____ Date:_____
Patient/Insured (Parent or Guardian if patient is a minor)

Signature:_____ Date:_____
Person accepting responsibility for fees & providing a copy of their credit/debit card

Witness:_____ Date: _____