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.

Kinetic Home Therapy Services LLC Patients:

Confidentiality of Your Health Care Information
This notice is required by law to tell you how *Kinetic Home Therapy Services LLC* and its affiliates protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's medical history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. *Kinetic Home Therapy Services LLC* receives PHI from you and your hospital. *Kinetic Home Therapy Services LLC* receives, uses and discloses your PHI for billing containing your insurance. Any other disclosure of your PHI use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations.

Permitted Uses and Disclosures of Your PHI
We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. We may disclose PHI to third parties that perform services for *Kinetic Home Therapy Services LLC* in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for *Kinetic Home Therapy Services LLC* in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law. We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities,

for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to' maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases we may deny your request for an amendment. 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. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the appropriate privacy office as noted below if you have questions about amending your PHI. You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the appropriate privacy office as noted below. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to *April 14, 2003.* Please contact the appropriate privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right. You have the right to get this notice by email.

You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that *Kinetic Home Therapy Services LLC* has violated your privacy rights. You may file a complaint with us by notifying the appropriate privacy office as noted below. We will not retaliate against you for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices from *Kinetic Home Therapy Services LLC*. I understand that this notice describes how my medical information may be used and disclosed and outlines my rights regarding the confidentiality of my health care information.

1. **Protected Health Information (PHI):** PHI includes individually identifiable information about my medical history, mental or physical condition, or treatment. Examples of PHI include personal information such as my name, address, contact details, social security number, date of birth, treatment records, and other relevant information.

2. **Permitted Uses and Disclosures of PHI:** *Kinetic Home Therapy Services LLC* is permitted to use or disclose my PHI for purposes such as health care treatment, payment of claims, billing of premiums, and other health care operations. PHI may also be disclosed to third parties or affiliates involved in the administration of my benefits, and they are obligated to protect the confidentiality of my information.

3. **Rights Regarding PHI:** I have the right to request corrections or updates to my PHI, request confidential communications through alternative means or addresses, and receive an accounting of certain disclosures made of my PHI. I also have the right to file a complaint if I believe that my privacy rights have been violated.

4. **Complaints:** I understand that I may file a complaint with *Kinetic Home Therapy Services LLC* or the U. S. Secretary of Health and Human Services if I believe that my privacy rights have been violated. I acknowledge that there will be no retaliation against me for filing a complaint.

I understand the content of this Notice of Privacy Practices and my rights regarding the privacy of my health information. By signing below, I acknowledge the receipt of this notice.

Patient Name: _____

Signature: _____ Date: _____

KINETIC
HOME THERAPY SERVICES LLC.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to *Kinetic Home Therapy Services LLC* to the insurance benefits otherwise payable to me by _____.

Name of Insurance Company

I understand that I am financially responsible to *Kinetic Home Therapy Services LLC* for any charges covered by this authorization.

_____ _____

Patient/Insurer's Signature Date

_____

Policy Number

CONSENT FOR TREATMENT

I, _____, hereby give my consent to the authorization personnel of *Kinetic Home Therapy Services LLC* to render treatment/therapy and, consultation to me as outlined in my plan of care that is authorized by physician.

I also authorize *Kinetic Home Therapy Services LLC* to act on my behalf with any necessary appeals in regard to services rendered that include any services pertaining to my physical and occupational therapy rehabilitation.

_____ _____

Patient Name/Signature Date

_____ _____

Patient Representative Date

_____ _____

Kinetic Home Therapy Services LLC Representative Date

KINETIC
HOME THERAPY SERVICES LLC.

PATIENT INTAKE FORM

PATIENT INFORMATION:

First Name: _____ **MI:** _____ **Last Name:**_____

Address:_____

City: _____ **State:** _____ **Zipcode:** _____

Home Phone: _____ **Cell Phone:** _____

Date of Birth (MM/DD/YYYY):_____ / _____ / _____ **Sex:** Male _____ Female_____

Marital Status: Single___ Married___ Divorced___ Widowed___

Work Status: Full-Time___ Part-Time___ Retired___ Student___

Emergency Contact: _____ **Relationship:** _____

Home/Cell Phone#: _____

Do you have Medicare? Yes_____ No_____

Are you currently receiving Home Health Services? Yes_____ No_____

(If Yes) please write the name of the agency:

_____

(If Yes) What type of Home Health Services are you receiving

_____

(If No) have you received services in past 60 days? Yes_____ No_____

(If Yes) please write the name of agency:

_____

(If Yes) when was the last Date of Service?(MM/DD/YY): _____ / _____ / _____

Were you ever treated for Out-Patient Physical Therapy before? Yes_____ No_____

If Yes, please write the last Date of Service (MM/DD/YYYY):_____ / _____ / _____

How did you hear about us? Website___ Google___ Yelp___ Social Media___ Brochure___

Doctor's Office___ Other (specify):_____

Who should we thank for this referral? _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance Company:_____

Policy or Claim#: _____ **Group#:**_____

Medicare #:_____ **Effective Date:**_____ / _____ / _____

SECONDARY INSURANCE INFORMATION:

Name of Insurance Company:_____

Insurance Company Telephone #: (_____) - _____ - _____

Policy Holder Name: _____

Patient Relationship to Policy Holder: Self___ Spouse___ Dependent___

Other(specify):_____

PHYSICIAN INFORMATION:

Name of Referring Physician:_____

Address:_____

City: _____ **State:** _____ **Zipcode:** _____

Physician Telephone #: (_____) - _____ - _____

ATTORNEY INFORMATION *(if applicable):*

Name of Attorney: _____

Address:_____

City: _____ **State:** _____ **Zipcode:** _____

Attorney Telephone #: (_____) - _____ - _____

I hereby authorize *Kinetic Home Therapy Services, LLC* to treat me as per my doctor's prescription/ therapist's Plan of Care and to release to my Insurance company/Attorney/Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

_____ _____

Signature Date

Kinetic Home Therapy Services LLC welcomes you to our practice!

We would like to extend a warm welcome for choosing our services. *Kinetic Home Therapy Services LLC* is focused on providing excellent patient care and comprehensive rehabilitation services to reestablish and optimize your quality of life.

To accomplish optimal results with your therapy sessions, it is vital to be consistent with your program. *In the chance that you need to cancel any appointment,* ***a 24-hour notice must be given.***

When your condition improves as a result of your therapy program, please consider sharing your positive experience with us, as well as with your family and friends. Be sure to thank your doctor for referring you to our services.

We appreciate your confidence in our services and we look forward to working with you.

Sincerely,

THE STAFF OF KINETIC HOME THERAPY SERVICES LLC

Visit us online at: www.kinetichometherapy.com

Email: kevin@kinetichometherapy.com

Tel: 973-907-0924

Fax: 973-860-1332