TurningPoint
BREAST CANCER REHABILITATION

HIPAA - Consent Form

Print Name:

First Name:_____ Last Name: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected healthcare operations information.

The notice contains a person's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified.

You have the right to restrict how your protected healthcare operations information is used and disclosed for payment and/or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected healthcare operations information may be disclosed or used for payment, or healthcare operations.
- TurningPoint reserves the right to change the privacy policy as allowed by law.
- TurningPoint has the right to restrict the use of the information.
- The person has the right to revoke this consent in writing at any time and all full disclosures will then cease.

_____ _____

Signature Date

TurningPoint
BREAST CANCER REHABILITATION

TURNINGPOINT BREAST CANCER REHABILITATION, INC.

Patient Name: _____ **D.O.B.** _____

CONSENT TO EVALUATE/INITIATE TREATMENT

I do hereby consent to the evaluation and initiation of treatment by TurningPoint Breast Cancer Rehabilitation, Inc.

Patient Signature: _____ **Date:** _____

If signed by an Authorized Representative:

Authorized Representative Name: _____

Authorized Representative Signature _____ **Date:** _____

INSURANCE FILING, RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that payment is due at time of service. TurningPoint Breast Cancer Rehabilitation, Inc. generally files insurance as a courtesy to its patients. However, if there is an outstanding deductible or a co-pay due, I understand that this amount is payable at the time of service.

I hereby authorize TurningPoint Breast Cancer Rehabilitation, Inc. to release information from my medical records to any third party payer (such as an insurance company or government agency), or any person employed by such carrier for the purpose of collecting insurance benefits. This authorization includes release of information to employers for group insurance coverage, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release this practice from any and all responsibility relative to release of such information.

I assign direct payment to this practice of all benefits payable which are applicable to my treatment and grant this practice Power of Attorney in the collection of benefits. This assignment is applicable to all future charges and fees from, and including, this day forward, unless otherwise revoked by me in writing.

FOR MEDICARE PATIENTS ONLY: I request that payment of authorized Medicare benefits be made on my behalf to TurningPoint Breast Cancer Rehabilitation, Inc. for services rendered by them. I authorize any holder of medical information about me to release to the Health Care Financing Administrator and its agents any information needed to process my claim for benefits. I understand that if I do not have supplemental insurance coverage, or if my supplemental insurance pays me directly, I will be responsible for the 20% co-insurance portion not paid by Medicare, as well as any deductible.

Patient/Authorized Representative Signature: _____ **Date:** _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT PRIVACY PRACTICES

TurningPoint Breast Cancer Rehabilitation, Inc.'s Notice of Patient Information Practices provides information about how we may use and disclose protected health information about you.

By signing below, you acknowledge that you have received our Notice of Patient Information Practices on the date indicated below.

Patient Name: _____

Patient Signature: _____ **Date:** _____

If signed by an Authorized Representative:

Authorized Representative's Name: _____

Authorized Representative's Address: _____

Authorized Representative's Signature: _____ **Date:** _____

Reason Patient is Unable to Sign: _____

☐ **Received Verbal Consent From Capable Patient if Unable to Sign**

FOR OFFICE USE ONLY:

Date Notice of Patient Information Practices provided to patient: _____

Method of delivery (e.g., in person, electronically, etc.): _____

If unable to obtain a written Acknowledgement of Receipt of Notice of Patient Information Practices, please indicate the reason why:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for signature by return mail.
- ☐ Unable to communicate with the patient for the following reason: _____
- ☐ Other: _____

Prepared By: _____

Signature: _____ **Date:** _____

TurningPoint Breast Cancer Rehabilitation
Informed Consent for Physical Therapy Services

Physical therapy (PT), also known as physiotherapy, is meant to evaluate and treat abnormal physical function (i.e., musculoskeletal injury or movement dysfunction) by use of rehabilitative procedures, physical agents and modalities, mobilization, massage, and exercises to help improve endurance, strength, or range of motion. PT helps decrease pain and improve mobility and is meant to reduce the length of functional recovery. It is not possible to accurately predict a response to PT, as responses vary for each individual. TurningPoint Breast Cancer Rehabilitation (TurningPoint) does not guarantee a certain reaction to a specific treatment, nor does it guarantee that the treatment will help resolve the condition being treated. Furthermore, there is a possibility that the PT treatment may result in aggravation of existing symptoms and may cause pain or injury.

You have the right to be informed about your condition and the recommended PT services to be used so that you can make the decision whether to undergo the suggested treatment. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the planned treatment based on your individual history, PT diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

This consent form provides us with your permission to perform the reasonable and necessary medical services to complete your specific treatment plan. By signing this consent form, you voluntarily request a Physical Therapist or Physical Therapy Assistant to provide reasonable and necessary PT services and treatment for the condition being treated. You acknowledge that, in order to provide reasonable and necessary PT services and treatment for the condition being treated, it may be necessary for the Physical Therapist or Physical Therapy Assistant to have reasonable and necessary physical contact with your body. As an example, the Physical Therapist or Physical Therapy Assistant may need to touch you to massage a muscle to promote proper movement and function. In addition, you consent to receive services from other providers as may be deemed necessary to treat the underlying condition.

By signing below, you attest that you have read this consent form and understand the risks involved in PT. You consent to treatment at this office and agree to fully cooperate, participate in all PT procedures, and comply with the established treatment plan. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You also authorize the release of any medical information to appropriate third parties in accordance with applicable law and TurningPoint's Notice of Information Practices.

Patient Name_____ **Signature**_____ **Date**_____

TurningPoint
BREAST CANCER REHABILITATION

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.

TurningPoint Breast Cancer Rehabilitation's LEGAL DUTY

TurningPoint Breast Cancer Rehabilitation is required by law to protect and maintain the privacy of your personal health information, provide patients this notice about our legal duties and privacy information practices with respect to protected health information, notify affected patients following a breach of unsecured protected health information and follow the information practices that are described herein.

An extensive Notice of Privacy Practices as well as a General Privacy Policy are both available for reference upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

TurningPoint Breast Cancer Rehabilitation uses your personal health information primarily - to provide you with medical treatment which may include sharing your health information with other professionals who are treating you; to bill for and receive payment from health plans or other applicable entities for your treatment; conduct internal administrative activities; run our organization, evaluate and improve, as needed, the quality of care that we provide to our patients; and contact you when necessary for appointment reminders and to offer information concerning treatment alternatives or other health related benefits that could be of interest to you. We will never share your health information without your written permission for marketing purposes, the sale of your information, or providing most psychotherapy notes.

TurningPoint Breast Cancer Rehabilitation may also use or disclose your personal health information (to third parties) without prior authorization to assist with public health and safety issues for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications as well as suspected abuse, neglect, or domestic violence and reducing a serious threat to a patient's health or safety; conduct health research studies; comply with federal and state laws; reply to organ and tissue donation requests from organ procurement organizations; work with a coroner, medical examiner or funeral director upon the death of an individual; address workers' compensation claims, law enforcement, health oversight agencies and other governmental requests; disclose information to law enforcement about a decedent or individual that has died if there is a suspicion that the death may have resulted from criminal conduct; and respond to lawsuits and legal actions including, but not limited to, judicial and administrative proceedings.

In any other situation, TurningPoint Breast Cancer Rehabilitation's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a

written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.
TurningPoint Breast Cancer Rehabilitation 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 patient exam areas 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

As a patient, you have the right to (1) Review or obtain a copy of your personal health information at any time; (2) Ask that we correct any inaccurate or incomplete information in your records; (3) Request restrictions on certain uses and disclosures of protected health information about you to perform your treatment, for payment or health care operations; and (4) Obtain a record of instances where we have disclosed your personal health information without your prior authorization for the reasons listed in the "USES AND DISCLOSURES OF HEALTH INFORMATION" section above; TurningPoint Rehabilitation is not required to agree to a requested restriction other than for treatment, payment and/or health care operations.

In addition, you have the right and choice to inform TurningPoint Breast Cancer Rehabilitation to share your health information with your family, close friends, guardian or others involved in your care, in a disaster relief situation, to be included in a hospital directory or fundraising efforts. After our initial contact for funding raising efforts, you may inform us not to contact you again.

CONCERNS AND COMPLAINTS

If you are concerned that TurningPoint Breast Cancer Rehabilitation may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on TurningPoint Breast Cancer Rehabilitation health information practices or if you have a complaint, please contact the following person:

Attn: Carmelita White
Telephone: 770-360-9271 Fax: 770-360-9276

TurningPoint Breast Cancer Rehabilitation will not retaliate against a patient for filing a complaint.

EFFECTIVE DATE

This, Notice of Patient Information Practices, is effective on July 8, 2019.