PHYSICAL THERAPY @ THE PACIFIC CLINIC
1350 NORTH GRANT STREET KENNEWICK, WA 99336 PHONE: (509) 735-2014 FAX: (509) 735-3980

POLICIES

PATIENT NAME: _____ DATE OF BIRTH: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT - (HIPAA)

I UNDERSTAND COURT CLUB PT WILL USE AND DISCLOSE HEALTH INFORMATION ABOUT ME IN COMPLIANCE WITH THE HIPAA ACT. I UNDERSTAND I AM ENTITLED TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES AS OUTLINED BY FEDERAL REGULATIONS. I HAVE THE RIGHT TO ASK THAT SOME OR ALL OF MY HEALTH INFORMATION NOT BE USED OR DISCLOSED IN THE MANNER DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I ALSO UNDERSTAND COURT CLUB PT IS NOT REQUIRED BY LAW TO AGREE TO SUCH REQUESTS. MY SIGNATURE BELOW ACKNOWLEDGES I AM AWARE OF MY RIGHTS IN ACCORDANCE TO HIPAA.

I AUTHORIZE COURT CLUB PT, TO RELEASE MY MEDICAL AND/OR BILLING INFORMATION TO THE FOLLOWING INDIVIDUAL(S):

1. _____ RELATION TO PATIENT: _____

2. _____ RELATION TO PATIENT: _____

I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE DISCLOSED. I UNDERSTAND THAT INFORMATION DISCLOSED TO ANY ABOVE RECIPIENT IS NO LONGER PROTECTED BY FEDERAL OR STATE LAW AND MAY BE SUBJECT TO DISCLOSURE BY THE ABOVE RECIPIENT. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING.

LATE ARRIVALS, CANCELLATIONS & NO SHOWS

IT IS EXPECTED THAT YOU KEEP ALL YOUR APPOINTMENTS. IF YOU NEED TO RE-SCHEDULE AN APPOINTMENT, WE REQUIRE 24 HOURS' NOTICE. IN SUCH A CASE, PLEASE CALL OUR OFFICE AND ARRANGE FOR A MAKE-UP APPOINTMENT WITH OUR FRONT DESK.

- LATE CANCELS, CANCELS GIVEN WITH LESS THAN 24 HOURS' NOTICE, MAY RESULT IN A $50.00 FEE.
- NO-SHOWS, WILL RESULT IN A $50.00 FEE.

IT IS IMPORTANT THAT YOU ARRIVE AND ARE READY TO START AT THE TIME OF YOUR SCHEDULED APPOINTMENT.

- LATE ARRIVAL OF 10 MINUTES OR MORE MAY RESULT IN CHANGES TO AND/OR LOSS OF THE ABILITY TO SCHEDULE FUTURE APPOINTMENTS.
- LATE ARRIVAL OF 20 MINUTES OR MORE IS CONSIDER A LATE CANCEL. THIS WILL RESULT IN CANCELLATION OF YOUR APPOINTMENT AND A $50.00 LATE CANCEL FEE.

WE RESERVE THE RIGHT TO DISCONTINUE CARE DUE TO REPEATED NONCOMPLIANCE WITH YOUR SCHEDULED VISITS.

THANK YOU FOR CHOOSING COURT CLUB PT. IF YOU HAVE ANY QUESTIONS ABOUT OUR POLICIES PLEASE ASK.

I HAVE READ AND UNDERSTAND THESE POLICIES AND AGREE TO COMPLY WITH THE POLICES SET FORTH ABOVE.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____