# NEW ERA Physical Therapy

**615 West Mermod. Carlsbad, NM 88220**
**Phone: (575)- 200-3465   Fax: (575)- 200-3470**

## INSTRUCTIONS

- Please bring your **INSURANCE CARD** and a **VALID ID** (ex. driver's license) to every appointment.
- Please come at least 15 min prior to your scheduled PT Initial Evaluation.
- If you haven't filled out a new patient packet, please come in at least 30 minutes early, so you can fill this out prior to your evaluation. You can arrange to have this packet emailed to you, or you can pick up a copy a few days prior to your scheduled appointment.
- Please wear comfortable (loose fitting, if possible) clothing, and closed shoes to all of your appointments. FOR YOUR SAFETY, NO OPEN TOE SHOES PLEASE.
- **Please bring ALL OF YOUR MEDICATIONS to your initial evaluation appointment, including vitamins, herbal medicine, and other over-the-counter medications.**
- Please come to all your appointments on time.
- We may have to reschedule if you are more than 15 minutes late for your appointment.
- Please bring all your emergency medications with you (ex. Epipen, asthma medication, etc).
- **There will be a $40.00 charge for any missed appointments not cancelled 24 hours prior to your given appointment time. Please, be aware your insurance will not cover this fee.**

_____________________________________________ / ______________________

**Signature** **Date**

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## PATIENT REGISTRATION

Name ____________________________________________________________ Date ______________________
Last First MI

Mailing Address_____________________________________________________________________________________
Street City State Zip Code

Physical Address_____________________________________________________________________________________
Street City State Zip Code

Home Phone w/area code ________________Work Phone __________________ Cell Phone ___________________

Contact Preference: __Home __Work __Cell E-mail Address______________________________________

Social Security Number ________________________ Date of Birth _____________________ Sex: __ Female __ Male

Marital Status: __Single __Married __Domestic Partner __ Divorced __ Widowed

Spouse/Partner's Name: __________________________________________________________________________

Your Employer ___________________ Employer's Address ______________________________________________

Employer's Phone Number ________________________

Emergency Contact__________________________________________Relationship__________________________

Home Phone w/area code ________________Work Phone __________________ Cell Phone ___________________

Primary Care Physician _______________________________________ Phone Number ________________________

Referring Physician __________________________________________ Phone Number ________________________

**INSURANCE INFORMATION – PLEASE PROVIDE INSURANCE CARDS & A VALID ID TO THE FRONT DESK FOR SCANNING**

Primary Insurance ___________________________________________________________________________

Subscriber's Name ______________________________________________ Date of Birth ______________________

ID Number ______________________________________ Group Number __________________________________

Secondary Insurance _________________________________________________________________________

Subscriber's Name Birth date ____________________________________________________________________

ID Number ______________________________________Group Number __________________________________

**PLEASE TURN OVER**

| PLEASE COMPLETE THIS SECTION WHETHER OR NOT THIS IS RELATED TO ACCIDENT (IF NOT MARK "N/A") |
| --- |
| Date of accident ___________________________________     __ Auto __ Work __ Other |
| State in which injury occurred_______________________     Claim Number______________________________________ |
| Insurance Company (worker's comp or your auto PIP) _____________________________________________________________ |
| Address____________________________________________________________________________________________________ |
| Claims Adjuster___________________________________________________ Phone number_____________________________ |

**I verify that the above information is accurate.**

_____________________________________________________/_________________
(Signature/Date)

# NEW ERA Physical Therapy

**615 West Mermod. Carlsbad, NM 88220**
**Phone: (575)- 200-3465   Fax: (575)- 200-3470**

**PATIENT HEALTH HISTORY**

Name ______________________________________________________________ Date ______________________
Last                    First                         MI

Note: Please answer the questionnaire as accurately as possible. Please feel free to ask your therapist or any of the staff for assistance.

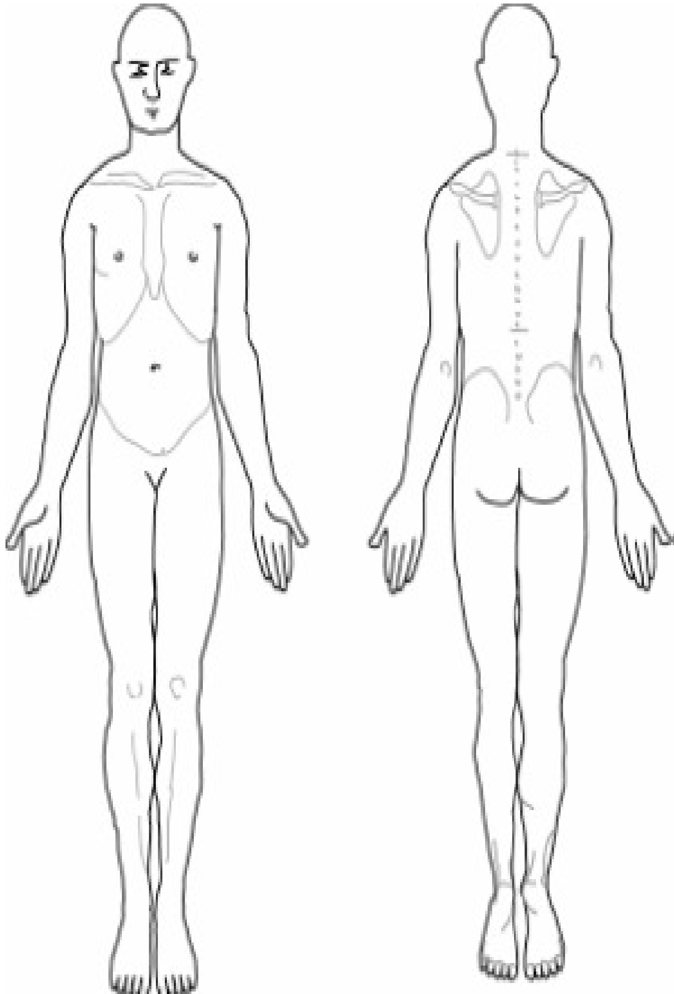
**HISTORY OF PRESENT ILLNESS**

1. **Please describe your symptoms.**

____________________________________________________________________________________________

____________________________________________________________________________________________

Please mark areas of **pain** or **abnormal** sensation on the body chart below. Please indicate your pain scale for each affected area that you are seeking therapy for. You can use the pain rating scale guide on the right side for reference.



Please put number pain scale on the figure shown on the left.

**Nature of pain/symptoms (check all that apply)**

____sharp   ___dull   ___throbbing

____aching   ___periodic   ___occasional

___ constant

___other (specify)_______________________________

_____________________________________________

**VITAL SIGNS: (for clinic use only)**

BP:______ /______ 02:__________ PR:__________

Temp:__________

**2. When did your symptoms begin?**
(Please indicate a specific date if possible)

______________________________________________

**3. Was the onset of this episode gradual or sudden?**(Please check one)

__ gradual __ sudden

**4. Which of the following best describes how your injury occurred?** *(*if your condition is post-surgical please indicate as per original injury*)*

__ lifting __ blow to the face
__ MVA (car accident __ being hit by a ball
__ fall __ dental appointment
__ trauma __ throwing
__ degenerative process __ an incident at work
__ during recreation/sports __ unknown
__ running __ other
__ overuse (cumulative trauma)
Please specify __________________________________

**5. Since onset, are your symptoms getting:** (Check one)

__ better __worse __not changing

**6. Have you had similar symptoms in the past?**

__ Yes __No

**More than one episode?** __Yes __ No

**7. Nature of pain/symptoms (check all that apply)**

__ sharp __dull __ throbbing
__ aching __periodic __occasional
__ constant __ other ______________________

**8. As the day progresses, do your symptoms:** (Check one)

__ increase __decrease __ stay the same

**9. Does the pain wake you at night?**

__ No __ Yes

**If "yes", is it present** __while lying still
__changing positions only
__both

**10. Do you have pain/stiffness upon getting out of bed in the morning?** __ Yes __ No

**11. In what position do you sleep?** (Check all that apply)

__ right side __ back
__ left side __ stomach
__chair/recliner __other __________________

**12. Since the onset of your current symptoms have you had:**

__ fever/Chills __numbness
__numbness __weakness
__night pain/sweats
__difficulty with bowel or bladder control
__any numbness in the genital or anal area
__any dizziness or fainting attacks
__unexplained weight change
__malaise (vague feeling of bodily discomfort)
__problems with vision/hearing
__none of the above

**13. What aggravates your symptoms?** (Check all that apply)

__sitting __lying down
__walking __stress
__up/down stairs __standing
__reaching overhead __squatting
__reaching in front of body __sleeping
__reaching behind back __coughing/sneezing
__reaching across body __taking a deep breath
__going to/rising from sitting
__ repetitive activities (specify)__________________
__household activities (specify)__________________
__talking __ chewing __yawning
__looking up overhead __swallowing
__recreation/sports (specify)____________________
__ sustained bending
Other (specify) ________________________________

NEW ERA Physical Therapy

**14. What relieves your symptoms? (Check all that apply)**

__ sitting __ rest __ massage
__ Heat __ standing __ medication
__ cold __ walking __ nothing
__ stretching __ exercise __ other______________
__ lying down __ wearing a Splint/orthosis

**15. Have you had any previous treatment for this condition?** (Check all that apply)

__none __hypnosis
__medication (oral) __biofeedback
__ joint manipulation __TENS unit
__exercise __acupuncture
__massage therapy __bed rest
__traction __overnight
__bracing/taping __hospitalization
__injection into the spine
__ injection into the skin/muscles
__casting __physical therapy
__other (specify) _______________________________

**16. Have you had any of the following tests?**

__ None __ Bone Scan
__x-rays __ NCS
__CT Scan __ Fluoroscope
__MRI __ Vestibular
__Arthrogram __ other
__Stress X-ray Test (Telos)
__Test Results:________________________________

## MEDICATIONS

**Please list any prescription medications you are currently taking** (pain pills, injections and/or skin patches, etc.):

Prescribing MD: ____________ Phone: _____________

**Are you currently taking any of the following over the counter medications?**

__ aspirin __ Advil/Motrin/ Ibuprofen
__Tylenol __corticosteroids
__antihistamines __vitamins/mineral supplements
__ See attached
__ other (specify)______________________________

## PRIOR LEVEL OF FUNCTION

**__Independent in all activities** (work, community, home, recreation)

**Self-care**

__Independent in all self-care activities (bathing, toileting, dressing, etc.)
__Difficulty performing self-care activities
__Need assistance with self-care activities
__Difficulty performing household chores

**Social**

__Need assistance with activities in community outside of home

**Hobbies:**_____________________________________

## WORK HISTORY

**Occupation:** __________________________________

__employed full time __student
__employed part time __retired
__self employed __unemployed
__homemaker __other

**Physical activities at work** (check all that apply)

__sitting __computer use
__standing __heavy equipment operation
__phone use __repetitive lifting
__driving __heavy lifting
__other (specify) ______________________________

**Are you currently receiving or seeking disability for this condition?** __Yes __No

**If not performing your normal activities at work do you plan to RETURN to your previous activity level?**

__Yes __No

## LIVING SITUATION

__ live alone __assisted living
__live with family members/others
__live with caregiver __home/apartment
__retirement complex (SNF/ICF)
__ other (specify)______________________________

**Setting**

__ stairs (railing) __no stairs
__stairs (no railing) __ ramp
__elevator __uneven ground
__ other (specify)________________________________

**GENERAL HEALTH**

**How would you rate your general health?**

__Excellent __ Average __Poor
__Good __ Fair

**Do you exercise outside of normal daily activities?**

__5+ days/wk __1-2 days/wk __zero
__3-4 days/wk __occasionally

Exercise, Sports/Recreation consisting of:

______________________________________________

**Do you drink caffeinated beverages?**

__No __Yes How many/much per day___________

**Do you smoke?** __No __Yes

Packs of cigarettes per day _______________________

**What is your stress level?**

__Low __Medium __High

**Are you seeing any health care providers other than the physical therapist for this current condition?**
(Please list)_____________________________________

______________________________________________

**PAST MEDICAL HISTORY**

**Have you ever had/been diagnosed with any of the following conditions?** (Check all that apply)

__Cancer (type) __Heart problems
__Depression __High blood pressure
__Stroke __Lung problems
__Kidney problems __Blood disorders
__Thyroid problems __Epilepsy/seizures
__Diabetes Allergies __Multiple sclerosis
__Rheumatoid arthritis __Osteoarthritis
__Osteoporosis __Head injury
__Fractures __Digestive problems
__Circulation/Vascular __Parkinson's disease
__Infectious diseases (i.e. hepatitis, tuberculosis, etc.)
__ other (specify)________________________________

**Please list any recent/relevant past surgeries related to your current problem:**

| SURGERY | DATE |
| --- | --- |
| ________________________ | __________________ |
| ________________________ | __________________ |
| ________________________ | __________________ |

**Has anyone in your immediate family (parents, brothers, sisters) ever been treated of any of the following?**

__Diabetes __Cancer
__Heart disease __Arthritis
__High blood pressure __Osteoporosis

Please note any other pertinent information below:

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

**I verify that the above information is accurate.**

**PLEASE SIGN BELOW:**

_______________________/_________________
Signature / Date

NEW ERA Physical Therapy

**MEDICATION LIST**

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**LAST NAME** **FIRST NAME** **MI** **DOB** **DATE**

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
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**Patient Identification**

Printed Name: __________________________________________________________________ Date of Birth: ______________________

Address:______________________________________________________________________________________________________________
Street Address City St Zip

Social Security #:_____________________________________________________ Telephone: (_______)________________________________

**Information To Be Released – Covering the Periods of Health Care**

From (date) ___________________________________ to (date) ______________________________________

***Please check type of information to be released:***

| | | |
|---|---|---|
| Entire medical record | Pathology report | Discharge summary |
| History and physical exam | Consultation reports | Progress notes |
| Laboratory test results/reports | X-ray reports | X-ray films / images |
| Operative report | Emergency room record | Itemized bill |

Other, (specify) ____________________________________________________________________________________________________

**Purpose of Request**

| | | |
|---|---|---|
| Treatment or consultation | At the request of the patient | Billing or claims payment |

Other, (specify) ____________________________________________________________________________________________________

| **Facility Authorized to Receive Information** | | **Facility Authorized to Release Information** | |
|---|---|---|---|
| **Name:** | **New Era Physical Therapy** | **Name:** | ____________________________________________ |
| **Address:** | **615 W Mermod** | **Address:** | ____________________________________________ |
| **City:** | **Carlsbad** | **City :** | ____________________________________________ |
| **Phone:** | **575-200-3465** | **Phone:** | ____________________________________________ |
| **Fax :** | **575-200-3470** | **Fax :** | ____________________________________________ |

**Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release**
I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** **Yes** **No** ______________ **Initials**

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ***Check One:*** **Yes** **No** ______________ **Initials**

**Time Limit & Right to Revoke Authorization**
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at NEW ERA Physical Therapy, 615 W. Mermod St., Carlsbad, New Mexico 88220. Unless revoked, this authorization will expire on the following date or event_____________________________________

**Re-disclosure**
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Signature of Patient or Personal Representative Who May Request Disclosure**
I understand that *NEW ERA Physical Therapy* may not condition my treatment on whether I sign this authorization form unless specified above under **Purpose of Request**. I can inspect or copy the protected health information to be used or disclosed. **I authorize** *[__________________________]* **to use and disclose the protected health information specified above.**
***Name of Facility or Provider***

Signature: ________________________________________________________________________________ Date: ___________________________

Authority to Sign if not patient: ___________________________________________________________________________________________

Identity of Requestor Verified via**:** **Photo ID** **Matching Signature** **Other, specify** _______________________________________________

Verified by: _________________________________________________________

# New Era Physical Therapy

**Notice of Privacy Practices**
Effective Date: **November 2, 2015**
**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**
If you have any questions about this notice, please contact our privacy officer:


**Stella Addy**
**615 W. Mermod Street W.**
**Carlsbad, NM 88220**
**(575) 200-3465**


**1. Summary of Rights and Obligations Concerning Health Information.** New Era Physical Therapy is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by New Era Physical Therapy. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:
• plan your care and treatment;
• provide treatment by us or others;
• communicate with other providers such as referring physicians;
• receive payment from you, your health plan, or your health insurer;
• make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
• make you aware of services and treatments that may be of interest to you; and
• comply with state and federal laws that require us to disclose your health information.
We may also use or disclose your health information where you have authorized us to do so.
Although your health record belongs to New Era Physical Therapy, the information in your record belongs to you. You have the right to:
• ensure the accuracy of your health record;
• request confidential communications between you and your therapist and request limits on the use and disclosure of your health information; and
• request an accounting of certain uses and disclosures of health information we have made about you.
We are required to:
• maintain the privacy of your health information;
• provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
• abide by the terms of our most current *Notice of Privacy Practices*;
• notify you if we are unable to agree to a requested restriction; and
• accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
**We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain.**
Should our information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law. We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy Practices.* In the following pages, we explain our privacy practices and your rights to your health information in more detail.

**2. We may use or disclose your medical information in the following ways:**
***A. Treatment.*** We may use and disclose your protected health information to provide, coordinate and manage your rehab care. That may include consulting with other health care providers about your health care or referring you to another health care provider for treatment including physicians, nurses, and other health care providers involved in your care. For

example, we will release your protected health information to a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you.

***B. Payment.*** We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

***C. Health Care Operations.*** We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

***D. Students.*** Students/interns in rehabilitation or health service related programs work in our facility from time to time to meet their educational requirements or to get health care experience. These students may observe or participate in your treatment or use your health information to assist in their training. You have the right to refuse to be examined, observed, or treated by any student or intern. If you do not want a student or intern to observe or participate in your care, please notify your provider.

***E. Business Associates.*** New Era Physical Therapy sometimes contracts with third-party business associates for services. Examples include answering services, transcriptionists, billing services, consultants, and legal counsel. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require our business associates to appropriately safeguard your information.

***F. Appointment Reminders.*** We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment. We usually will call you at the home and/or the cell phone number you provided the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we call you only at a certain number or that we refrain from leaving messages and we will endeavor to accommodate all reasonable requests.

***G. Treatment Options.*** We may use and disclose your health information in order to inform you of alternative treatments.

***H. Release to Family/Friends.*** Our staff, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. However, please note that under New Mexico state law, if a child age eighteen (18) or older requests that their medical information not be disclosed to a parent or guardian, we must comply with their request. Please let your provider know if you would not like us to release information to a family member or friend.

***I. Health-Related Benefits and Services.*** We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you. In face- to-face communications, such as appointments with your provider, we may tell you about other products and services that may be of interest you.

***J. Newsletters and Other Communications.*** We may use your personal information in order to communicate to you via newsletters (including electronic newsletters), mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

***K. Disaster Relief.*** We may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and

condition. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

***L. Marketing.*** In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may provide you with promotional gifts of nominal value. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

***M. Public Health Activities.*** We may disclose medical information about you for public health activities. These activities generally include the following:

- licensing and certification carried out by public health authorities;
- prevention or control of disease, injury, or disability;
- reports of births and deaths;
- reports of child abuse or neglect;
- notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- organ or tissue donation; and
- notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required by law, or if you agree to the disclosure, or when authorized by law and in our professional judgment disclosure is required to prevent serious harm.

***N. Food and Drug Administration (FDA).*** We may disclose to the FDA and other regulatory agencies of the federal and state government health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing monitoring information to enable product recalls, repairs, or replacement.

***O. Research.*** We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.

***P. Workers Compensation.*** We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

***Q. Law Enforcement.*** We may release your health information:

- in response to a court order, subpoena, warrant, summons, or similar process of authorized under state or federal law;
- to identify or locate a suspect, fugitive, material witness, or similar person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct New Era Physical Therapy;
- to coroners or medical examiners;
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime;
- to authorized federal officials for intelligence, counterintelligence, and other national security authorized by law and;
- to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

***R. De-identified Information.*** We may use your health information to create "de-identified" information or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

***S. Personal Representative.*** If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

***T. Limited Data Set.*** We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research, public health, and health care operations. We may not disseminate the limited data set unless we enter into a data use agreement with the recipient in which the recipient agrees to limit the use of that data set to the purposes for which it was provided, ensure the security of the data, and not identify the information or use it to contact any individual.

**3. Authorization for Other Uses of Medical Information.** Uses of medical information not covered by our most current *Notice of Privacy Practices* or the laws that apply to us will be made only with your **written authorization**. You should be aware that we are not responsible for any further disclosures made by the party you authorize us to release information to. If you provide us with authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization or, if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim or the insurance coverage itself. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care that we provided to you.

**4. Your Health Information Rights.** You have the following rights regarding medical information we gather about you:

***A. Right to Obtain a Paper Copy of This Notice.*** You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

***B. Right to Inspect and Copy.*** You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical information, we may charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act (such as claims for Social Security, Supplemental Security Income, and any other state or federal needs-based benefit program).
If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record.

***C. Right to Amend.*** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information.
To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for New Era Physical Therapy;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

***D. Right to an Accounting of Disclosures.*** You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations. However, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;

• disclosures made to create a limited data set;
• disclosures made directly to you.
To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by e-mail). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

***E. Right to Request Restrictions.*** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we are required to honor that request. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care.
Except as noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us:
• what information you want to limit;
• whether you want to limit our use, disclosure, or both; and
• to whom you want the limits to apply.

***F. Right to Request Confidential Communications.*** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to your provider or our privacy officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

***G. Right to Receive Notice of a Breach.*** We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:
• a brief description of the breach, including the date of the breach and the date of its discovery, if known;
• a description of the type of Unsecured Protected Health Information involved in the breach;
• steps you should take to protect yourself from potential harm resulting from the breach;
• a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
• contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information. In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of the U.S. Department of Health and Human Services of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

**5. Complaints**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred. See the Office for Civil Rights website, www.hhs.gov/ocr/hipaa/ for more information. You will not be penalized for filing a complaint