COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint in writing with the facility (Southern Tier Physical Therapy) or with The Office of Civil Rights in the U.S. Department of Health and Human Services.
To file a complaint with the facility, contact Kris Secord, Office Manager.
We will not retaliate against you if you file a complaint.

CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provision effective for all personal health information already received and maintained by the facility as well for all personal health information we receive in the future. We will post a copy of the current Notice in the facility. In addition, we will provide a copy of the revised Notice to all patients via U.S. mail.

FOR FURTHER INFORMATION

If you have any questions about this Notice, please contact Kris Secord, Office Manager.

EFFECTIVE DATE: January 1st, 2016

I have read a copy of the Southern Tier Physical Therapy Notice of Privacy Practices.

_____ _____

**** PATIENT SIGNATURE (Parent/Guardian if under 18 years of age)** **DATE**

CONTENT:

I authorize the release of medical information, including evacuation and treatment notes, from Southern Tier Physical Therapy that are necessary to process any claim.

It is the patient's responsibility, and we strongly encourage each patient to verify their physical therapy benefits for the year with their individual insurance carriers.

The patient is responsible for any payments in the event that they have exhausted their benefits, do not provide proper referral or authorization, etc.

I authorize payment for any physical therapy service, including supplies. I understand that if I receive any services or supplies (i.e. Ionto pads) that are denied or not covered by my insurance company, that I will be responsible for the bill.

Patient is responsible for all co-pays at the time of service.

There will be a $20.00 service charge for all returned checks.

_____ _____

**** PATIENT SIGNATURE (Parent/Guardian if under 18 years of age)** **DATE**

We do not / can not bill for appointments that are cancelled or no showed.
~ ~ ~ The courtesy of a 24 hour notice is appreciated. ~ ~ ~
Please note, we reserve the right for discharge from our services in the event of three (3) no shows or cancellations done without the courtesy of a 24 hour notice.