Onsite Therapy Resources LLC

NOTICE OF PRIVACY PRACTICES

Effective Date: July 27, 2009

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED – PLEASE REVIEW CAREFULLY

1. My Duty to Safeguard Your Protected Health Information (PHI)

Individually identifiable information about your past, present, or future health or condition, the delivery of health care services to you, or payment for health care services is considered "**P**rotected **H**ealth **I**nformation" (PHI). I am required to follow privacy practices as described in this notice. I reserve the right to change my privacy practices and the terms of this notice at any time within compliance of applicable law.

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2. How I May Use and Disclose Your Protected Health Information

Generally, I am permitted to use and/or disclose your PHI for Treatment, Payment for services you receive, and for normal health care operations (TPO). For most other uses and/or disclosure of your PHI, you will be asked to grant permission via a signed authorization. However, I am permitted to make certain other uses and/or disclosures of your PHI without your authorization. Uses and/or disclosures are permitted as follows:

Uses and/or Disclosures Related to Your Treatment, My Payment, or My Health Care Operations (TPO):

Treatment
I may exchange your PHI with your doctor, dentist, or other healthcare provider to make sure you receive proper care.

Payment
I may exchange your PHI with health insurance plans or Workers' Compensation programs to make sure the treatment you receive is paid for.

Health Care Operations
I may exchange your PHI with other Business Associates and health care review organizations to conduct quality assessment and improvement activities and to engage in care coordination or case management.

Appointment Reminders

Unless you request that I contact you by other means, I am permitted to send appointment reminders or similar materials to your address.

Uses and/or Disclosures That Require Your Authorization

Generally, most uses and/or disclosures of your PHI for purposes other than TPO will require your signed Authorization. You retain the right to revoke your Authorization at any time except to the extent that I have already undertaken an action in reliance upon your Authorization.

Uses and/or Disclosures That Do Not Require Your Authorization

- When required by law to report abuse, neglect or domestic violence
- For public health activities
- For health oversight activities
- To comply with state workers' compensation laws
- For judicial and administrative proceedings
- To comply with law enforcement activities
- For coroners, medical examiners and funeral directors about decedents
- For medical research purposes
- To prevent a serious threat to health or safety
- For specific government functions and national security purposes

Uses and/or Disclosures to Which You Have an Opportunity to Object

- To families, friends or others involved in your care

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3. Your Rights Regarding Your Protected Health Information (PHI)

- The right to request restrictions on PHI uses and/or disclosures
- The right to request confidential communications
- The right to request amendment of your PHI
- The right to an accounting of disclosures of your PHI

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4. How to Complain about Privacy Practice Violations

If you believe that I have violated your privacy rights, you may submit your written complaint to the Secretary of the U.S. Department of Health and Human Services. Your written complaint must name the entity or person that is the subject of your complaint and describe the acts and/or omissions you believe to be in violation of the provisions outlined in this Notice of Privacy Practices. Your complaint must be filed within 180 days of when you knew, or should have known, the act or omission occurred. No retaliatory action will be taken against you if you make a complaint.

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Therapy Services Rights & Responsibilities

You were referred for therapy services. I am a Physical Therapist registered nationally, licensed in the state of Ohio, and certified with BWC. I have been privileged to work with Ohio's injured workers since 1986. I am committed to providing safe and professional service to assist with your rehabilitation, return to work, or case resolution. Do not hesitate to ask questions if anything is unclear or if you need further information. I pledge to treat you with courtesy and respect and request that you do the same. Please take time to review your Rights and Responsibilities outlined below.

You have the right …

- To be treated with courtesy and respect.
- To protection of your need for privacy and confidentiality.
- To choose any BWC Certified Provider.
- To receive a prompt and reasonable response to questions and requests.
- To refuse treatment or services and be notified of the implications, if any, of such refusal.
- To be notified of the circumstances when information obtained can be disclosed to a third party under Ohio workers' compensation laws and rules.
- To prompt and fair resolution of any valid complaint.

You have the responsibility …

- To cooperate with your providers in following the prescribed treatment and return to work plan to which you agreed.
- To keep appointments and when unable to do so for any reason, notify the health care provider.
- For your actions if you refuse treatment or do not follow the health care provider's instructions.
- To provide accurate and complete information about present complaints, past illnesses, hospitalizations, medication(s) and other matters relating to your health and workers' compensation injury, to the best of your knowledge.
- To report unexpected changes in your workers' compensation injury (ies) to your physician and other providers as quickly as possible.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I was given a copy of the 'Notice of Privacy Practices'
with an effective date of July 27, 2009.

Signature _____

Print Name _____

Date _____

Onsite Therapy Resources LLC

Therapy Services Rights & Responsibilities Acknowledgement

I was given a copy of the 'Therapy Services Rights & Responsibilities' statement.

Signature _____

Print Name _____

Date _____