

CHECKLIST FOR PEDIATRIC PATIENTS

Before your scheduled appointment, carefully read and complete the forms in this download. Please bring the completed packet to your first appointment. We pride ourselves on starting our appointments on time. Please arrive fifteen minutes early to check in and review your completed paperwork, and to sign the Insurance Authorization Release which we will have for you in your file.

At the time of your appointment you will need:

- Your insurance cards for Primary and Secondary, if applicable.
- Your referral prescription from your physician
- Form: Consent for purposes of Treatment, Payment & Healthcare Operations
- Form: Pediatric Client History
- Form: Notice of Privacy Practices Acknowledgment

If you can't keep your appointment for any reason, please contact our office as soon as possible so that we may reschedule your appointment.

Thank you for choosing Healing Bridge Physical Therapy. Please feel free to contact us at 541-318-7041, anytime, with your questions or concerns.

Healing Bridge Physical Therapy
404 NE Penn Street Bend, OR. 97701
Phone: 541-318-7041 Fax: 541-388-3711
Email: pt@healingbridge.com

Welcome to Healing Bridge Physical Therapy. We hope to make your healing process with us as successful and comfortable as possible.

As a courtesy, we will be assisting with the task of processing insurance claims. However, it should be understood that it is your responsibility to pay for any amounts not covered by your insurance company. We can work with you in setting up a payment schedule if necessary. We would appreciate payment of your co pay portion, usually 20%, at the time of the visit, in order to keep our recordkeeping as accurate and as current as possible. It should also be noted that the actual amount of your copay portion may change due to circumstances surrounding deductibles and provider discounts. We will provide you with a monthly statement showing the amount of adjustments and payments made by you and your insurance company and any outstanding balance due.

If we are billing an insurance company for a worker's compensation claim, or motor vehicle accident, we request all information be brought to the first appointment. We require your personal insurance information for our files, in the event your claim is denied.

In the event an account becomes overdue, we will turn the account over to a collection agency. Any legal fees we pay to secure overdue balances will be added to the account and any treatment with our facility will be terminated.

We apologize for the amount of paperwork we are asking you to complete. All forms are necessary as our tax dollars are hard at work to ensure your protection and privacy. If you have any questions, please don't hesitate to ask. We are looking forward to providing you with a positive, caring atmosphere to facilitate your healing.

I have received a copy of the Notice of Privacy Practices for my own personal records.

Signature: _____ Date: _____

I have read and understand this letter and agree to the terms stated above. A copy of this letter has been given to me.

Signature: _____ Date: _____

Healing Bridge Physical Therapy
404 NE Penn Avenue Bend, OR, 97701
Phone: 541-318-7041 Fax: 541-388-3711

Cancellation Policy

We thank you for choosing Healing Bridge Physical Therapy. Our clinic is unique, not only in our specialization of care, but in the one-on-one 1- hour appointments that you receive. Therefore, we require a 24-hour cancellation notice for all cancellations. We reserve your appointment hour exclusively for you, and attempt to accommodate your schedule.

We understand that emergencies and illnesses may cause a cancellation. Therefore, we do not charge for the first missed appointment. A second missed appointment without 24-hour notice will result in a \$50.00 cancellation fee. Please call and leave a message on the answering machine if calling after hours or on the weekend. Include your name, time and date of the appointment.

Changing Appointment Times:

To maintain our standard of quality care and service in this ever changing world of fast-paced health care, we must operate our facility with optimal efficiency. To this end, we occasionally call our patients and request a schedule or time change for an appointment. If you receive such a call, we want to assure you that you have no obligation to change your pre-scheduled time if it is inconvenient for you. If you are able to change it, we fully appreciate your flexibility. Likewise, if you have a schedule change that conflicts with your physical therapy appointment, we encourage you to call as soon as possible for an alternative opening. If your schedule change is with less than 24 hours notice, but we are able to find an alternative appointment for you on the same day, you will not be charged the late cancellation fee.

Our main goal is to assist you in your recovery and we will make every effort to work with you to meet your scheduling needs. However, to continue to provide our specialized one-on-one service, we must minimize cancellations and maximize efficiency. Therefore, we must strictly enforce our cancellation policy. The cancellation fee is not billable to your insurance company and will be your responsibility.

Patients whose benefits are through Worker's Compensation, Motor Vehicle Accidents, COIHS and OMAP cannot be charged for missed appointments. For this reason, therapy may be discontinued after two missed appointments for those who do not adhere to our 24-hour cancellation policy.

Thank you for your understanding and cooperation.

**Healing Bridge Physical Therapy, Inc.
404 NE Penn Avenue
Bend, OR. 97701**

**Consent for purposes of Treatment, Payment &
Healthcare Operations**

I consent to the use or disclosure of my protected health information by Healing Bridge Physical Therapy, Inc. for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Healing Bridge Physical Therapy. I understand that treatment of me by my physical therapist may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or other healthcare operations of the facility. Healing Bridge Physical Therapy is not required to agree to the restrictions that I may request. However, if Healing Bridge Physical Therapy agrees to a restriction that I request, the restriction is binding on Healing Bridge Physical Therapy and my Physical Therapist.

I have the right to revoke this consent, in writing, at any time, except to the extent that my Physical Therapist and Healing Bridge Physical Therapy has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physical therapist, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Healing Bridge Physical Therapy's Notice of Privacy Practices prior to signing this document. The Healing Bridge Physical Therapy's Notice of Privacy Practices has been made available to me for review. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Healing Bridge Physical Therapy. The Notice of Privacy Practices for Healing Bridge Physical Therapy is provided in the waiting room of the facility and is also posted to their website. This Notice of Privacy Practices also describes my rights and Healing Bridge Physical Therapy's duties with respect to my protected health care information.

Healing Bridge Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient: _____
or Personal Representative

Name of Patient: _____
or Personal Representative

Date: _____

Description of: _____
Personal Representative's Authority

Pediatric Client History

Fill in the questionnaire as completely as possible. Return the completed form to the evaluating/treating therapist.

1. Child's Name _____
Birth Date _____ Age _____ Sex _____
2. Father's name _____ Home Phone _____
Address _____ City _____
State _____ Zip _____ Date of Birth _____
Employer _____ Occupation _____
Social Security Number _____
3. Mother's name _____ Home Phone _____
Address _____ City _____
State _____ Zip _____ Date of Birth _____
Employer _____ Occupation _____
Social Security Number _____
4. Marital Status (Please check) Married _____ Separated _____ Divorced _____
Widowed _____ Single _____
5. Person completing questionnaire _____
6. Insurance Info: Primary Insurance Co. _____
Subscriber _____ ID Number _____
Secondary Insurance _____
7. Child's regular physician _____
Address _____ City _____
State _____ Zip _____ Phone number _____
How long has the child been under this physician's care? _____
8. Who referred you to Healing Bridge/ Georgia Merrifield? _____

9. What are your primary concerns about your child?

- 10 Has your child been diagnosed as having any medical or educational conditions? _____
If yes, what? _____
11. Check which of the following specialists your child has seen/ is seeing:

<u>Specialty</u>	<u>Name of agency specialist</u>	<u>Date</u>	<u>Address</u>	<u>Phone</u>
Cardiologist	_____	_____	_____	_____
Orthopedist	_____	_____	_____	_____
Psychologist/ Psychiatrist	_____	_____	_____	_____

Specialty Name of agency specialist Date Address Phone

Ophthalmologist/
Optometrist _____

Speech Pathologist _____

Occupational
Therapist _____

Physical Therapist _____

Audiologist _____

Chiropractor _____

ENT _____

Other _____

School _____ Grade _____

School days _____ a.m. ____ p.m. ____ all day _____

Teacher _____

Grades repeated? _____ Grades skipped? _____

Has child been in a special classroom and/or attended any remedial classes?

Yes ____ No ____ If yes, describe what type, where, when

Family History

1. Name of Brothers/Sisters Age Sex Grade in school

Do these brothers/sisters live with child? _____

2. Names of others living in the home:

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

3. With whom/who does the child spend most of his/her day? _____

Name of others closely involved with child _____

4. How does you child choose to use his/her free time?

5. Does you child play appropriately with toys? _____ If no, explain

6. Who is generally responsible for the discipline and rule setting at home? _____

What methods are used and what seems most effective?

How does the child react to discipline?

Does the child have tantrums? _____ Have you observed any head banging or self destructive behavior? _____ If yes, explain

6. Are there any speech, physical or learning problems among other family members, relatives?

<u>Name</u>	<u>Relationship</u>	<u>Describe problem</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Has your family experienced any recent crisis or major change (stress) that you feel is important to your child's development (financial problems, moves, job changes, divorce/separation, death, etc.) If so, explain _____

Medical History

1. Pregnancy - Full term _____ Premature _____ If so, how many weeks _____
Mother's general health during pregnancy: Good _____ Fair _____ Poor _____. Problems encountered during pregnancy (illnesses, injuries, stress, bleeding, fainting spells, anemia, etc.) _____

Medications during pregnancy (please specify) _____

2. Labor – Length of total labor _____ Hard labor _____
Problems encountered _____

3. Delivery – Vaginal _____ Cesarean section _____ Anesthesia _____
Induced birth _____ Breech presentation _____
Forceps delivery _____
Elaborate on any delivery complications: _____

4. Birth – Child's weight _____ lbs. _____ oz. Length _____ inches
Complications – Jaundice _____ Cyanosis _____ Congenital defects _____
Limpness _____ Stiffness _____ Elaborate on above complications at birth and note others not included _____

Was there a need for? Oxygen _____ Transfusion _____ Tube feeding _____ If so, for how long ? _____

Were there any feeding difficulties? Yes ____ No ____ If yes, explain _____

Length of hospitalization following birth _____

Problems encountered during child's first month _____

5. List illnesses/ diseases child has had (other than the usual)

Illness _____ Age at that time _____

Illness _____ Age at that time _____

6. List injuries/operations child has had:

Injury/operation _____ Age _____

Injury/operation _____ Age _____

7. Has child had convulsions/seizures? Age ____ Type _____

Frequency _____ Medication _____

8. Child's general health at present – Good ____ Fair ____ Poor ____

Other regular medications, what are they for _____

Any physical disabilities? Yes ____ No ____

If yes, please describe _____

Any allergies? Yes ____ No ____ if yes, type _____

Any ear infections? Yes ____ No ____ if yes, frequency _____

Tubes? Yes ____ No ____ when _____

Developmental History

Check which of the following describes your child as an infant:

- | | |
|------------------------------------|---|
| 1. ____ Fussy, irritable | ____ Good, non-demanding |
| ____ Quiet | ____ Passive |
| ____ Active | ____ Liked being held |
| ____ Resisted being held | ____ Floppy when held |
| ____ Tense muscles when being held | ____ Good sleep patterns |
| ____ Irregular sleep patterns | ____ Over active, never still unless sleeping |

Comments:

Check which describes your child at present:

2. Mostly quiet Overly active
 Tires easily Talks constantly
 Impulsive Restless
 Stubborn Fights frequently
 Over reacts Exhibits frequent temper tantrums
 Usually happy Has nervous habits or tics
 Clumsy

 Has difficulty separating from primary caregivers
 Falls often Wets bed
 Poor attention span Cries infrequently
 Cries often Has difficulty learning new tasks
 Rocks self frequently

Give approximate ages at which child did the following routinely:

3. Held up head Belly crawled (while on stomach)
 Crawled on hands and knees Pulled to standing
 Sat alone Stood alone
 Walked

General impression of child's motor development:

4. Gross motor: slow normal advanced
Fine motor: slow normal advanced
Poor handwriting: yes no n/a
Any discrepancies in your impressions versus the schools: yes no
If yes, please explain
-
-

5. Self care:

Bottle fed yes no type of formula _____
Nursed yes no How long? _____
Problems with either yes no If yes, explain _____

Currently eats: Breast milk Formula
 Baby food Junior foods
 Mashed table foods Table

Objects to certain foods (texture, taste, etc.) List most common _____

Describe degree to which child routinely performs the following:

Feed self: all ___ most ___ some ___ rare ___

If feeds self, uses: bottle ___ fingers ___ spoon ___ fork ___

Bathes self: all ___ most ___ some ___ none ___

Undresses self: all ___ most ___ some ___ none ___

Is child toilet trained? Yes ___ no ___ If yes, at what age? _____

Bladder (daytime) ___ bladder (day and nighttime) ___ bowel ___

6. Has child achieved skills and then lost them? ___ If so, what and when _____

Sensory History

1. Vestibular (movement and gravity information) Check which of the following apply to your child:

___ Rocks while sitting

___ Likes being tossed in air

___ Fearful of heights

___ Likes merry-go-rounds

___ Gets car sick

___ Enjoys being rocked now
or as an infant

___ No fear of movement or falling

___ Jumps a lot

___ Good balance

___ Fearful of movement

___ Spins & whirls more than other

___ Prefers more quiet play as
opposed to more active play

Comments: _____

2. Tactile (touch information). Check which of the following apply to your child

___ Avoids "messy" things
(mud, finger paint, etc.)

___ Irritated by cloth or certain
textures

___ Dislikes unexpected touch

___ Prefers to touch rather than
being touched

___ Bangs head on purpose
(now or in the past)

___ Examines objects by putting
them into mouth

___ Isolates him/herself from
other children

___ Dislikes having face
washed or wiped

___ Objects to being touched

___ Dislikes being cuddled

___ Avoids using hands for
extended periods

___ Pinch, bite or otherwise
hurt others

___ Tends to feel pain less
than others

___ Strong likes or dislikes
toward food textures

- | | |
|--|---|
| <input type="checkbox"/> Excessively ticklish | <input type="checkbox"/> Dislikes hair washing |
| <input type="checkbox"/> Dislikes nail cutting | <input type="checkbox"/> Wants to handle everything |
| <input type="checkbox"/> Seeks lots of touch | |

Comments: _____

3. Proprioceptive (muscle and joint information) Check which of following apply:

- | | |
|---|--|
| <input type="checkbox"/> Holds hands in strange positions | <input type="checkbox"/> Good coordination with small things (i.e pencil, buttons, etc.) |
| <input type="checkbox"/> Walks on toes (or did when younger) | <input type="checkbox"/> Went from sitting to standing with little or no crawling |
| <input type="checkbox"/> Crept on tummy rather than hands or knees | |
| <input type="checkbox"/> Leaps from one position to the next, unable to move slowly from one to another | |

Comments: _____

4. Auditory: Check which of the following apply to your child:

- | | |
|---|---|
| <input type="checkbox"/> Responds negatively to unexpected or loud noises | <input type="checkbox"/> Has difficulty paying attention when there are other noises nearby |
| <input type="checkbox"/> Misses hearing some sounds | <input type="checkbox"/> Appears to be hard of hearing |
| <input type="checkbox"/> Seems to enjoy strange noises | <input type="checkbox"/> Has a diagnosed hearing loss |
| <input type="checkbox"/> Enjoys music | |
| <input type="checkbox"/> Wears a hearing aid | |

Comments: _____

5. Visual: Check which apply:

- | | |
|---|---|
| <input type="checkbox"/> Reversals in copying | <input type="checkbox"/> Happier in the dark |
| <input type="checkbox"/> Look very closely and carefully at pictures or objects | <input type="checkbox"/> Has difficulty discriminating shapes or colors |
| <input type="checkbox"/> Becomes very excited when there is a variety of visual objects | <input type="checkbox"/> Resists having eyes covered |
| <input type="checkbox"/> Has difficulty focusing on things close | <input type="checkbox"/> Has difficulty visually focusing on things far away |
| <input type="checkbox"/> Has difficulty maintaining eye contact with another person | <input type="checkbox"/> Wears glasses |
| <input type="checkbox"/> Sometimes shakes head in awkward manner | <input type="checkbox"/> Difficulty following an object across the room |
| <input type="checkbox"/> Shifts head to one side in order to look at an object | <input type="checkbox"/> Difficulty following an object tossed toward him/her |

Healing Bridge Physical Therapy NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT
YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET
ACCESS TO THIS INFORMATION**

PLEASE REVIEW IT CAREFULLY.

*If you have any questions about this notice, please contact the Office Manager
by calling 541-318-7041.*

This notice describes the procedures and practices that this clinic and its professional, support and administrative staff follow to protect the privacy of your health information.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, it may be in the form of written or electronic records or spoken words, and it may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, the doctor who referred you for physical therapy may be treating you for a medical or orthopedic condition and we may need to know about that and any other health problems that could complicate your treatment. We may use your medical history to decide what treatment is best for you. We will consult with your doctor and send reports about your treatment to the doctor. We do this to provide the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as telephoning your doctor and getting needed information. Family members and other health care providers may be part of your physical therapy outside this office and that may require us to provide information about you.

- **For payment.** We may need to disclose health information about you in order to bill your health plan or insurance company or other third party for your treatment in this clinic.

We may also need to tell your health plan or insurance company about a treatment you are going to receive in order to obtain prior approval, or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to manage the clinic and ensure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain treatments are effective for certain problems.

We may also disclose your health information to your health plan and other health care providers that care for you in order to help these plans and providers evaluate or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

- **Appointment Reminders.** We may contact you to remind you of your appointment.
- **Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may interest you.
- **Health-Related Products and Services.** We may tell you about health-related products or services that may interest you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive these communications, we will not use or disclose your information for these purposes.

OTHER CIRCUMSTANCES

We may use or disclose health information about you for the following purposes, in accordance with the requirements and limitations of state and other law:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence

communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report suspected abuse or neglect, non-accidental physical injuries or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

OTHER USES AND DISCLOSURES PURSUANT TO YOUR SIGNED AUTHORIZATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you sign an *Authorization* for us to use or disclose health 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 information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the Office Manager in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Correct.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request a correction as long as the information is kept by this office.

To request a correction, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to the Office Manager. We will provide you with one of these forms at your request.

We may deny your request for an amendment if your request 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 correct information that:

- We did not create, unless the person or entity that created the information is no longer available to make the correction
 - Is not part of the health information that we keep
 - You would not be permitted to inspect and copy
 - Is accurate and complete
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a record of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The record may also exclude any disclosures we have made based on your written authorization.

To obtain this accounting, you must submit your request **in writing** to the Office Manager. It must state the time period for which you want an accounting. The time period may not be longer than six years and may not include dates before March 1, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to the Office Manager. We will provide you with one of these forms at your request.

- **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 mail or e-mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to the Office Manager. 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.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

To obtain such a copy, contact the Office Manager.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice or a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Office Manager, c/o Healing Bridge Physical Therapy, 404 NE Penn Ave. Bend, OR. 97701. ***You will not be penalized for filing a complaint.***

Form PP02, rev 4/2/07