Elyte Care
PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES

In accordance with HIPAA privacy regulations, this agreement is to notify you as to how your medical protected health information (PHI) may be used or disclosed.

Under the law, we are required to maintain the privacy of this information, but may need to share protected health information (PHI) to others in order to process your claims or for health care operations, which may include but are not limited to: Receive payment from insurer, Verify insurance coverage, conduct in-house clinical audits, care co-ordination/management, accreditation, certification, licensing, or credentialing, disclosure to the Secretary of the United States Department of Health & Social Services, to prevent a serious threat to health or safety, Workman's Compensation, Public Health & Safety, legal, National Security or Law Enforcement, personal Physician, team Physician, Athletic Director or Coach, to you or your designee upon written request, other uses and disclosures of PHI will only be admitted after your written consent or authorization.

All evaluations, progress notes as well as significant changes in Medical Conditions will be reported via fax, phone, and or mail to your Referring Physician and possibly Primary Care Physician. All other medical requests will be sent via mail and not electronically due to HIPPA, additional costs will be incurred. All insurances will be verified with pertinent PHI being released to the Insurance Company(s) necessary to process claims. All patients will be asked to sign in at the Front Desk upon arrival and names will be announced. Part of treatment is performed in an open environment. Some claims are billed electronically. If you wish not to sign on the sheet, not to have your name announced, not to bill claims electronically, or not to be in an open area for treatment, please notify the receptionist immediately and we will attempt to make alterations to accommodate your needs. If you have any questions, please ask to speak to the Clinical Director.

In addition, please list all individuals with who we can discuss your health and billing information.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____ _____

Patient Signature Date