Florida West Coast Physical Therapy

Professional, Personalized, "Hands On" Care

256 S. Nokomis Ave., #2, Venice, FL 34285
(941) 484-1939 • Fax (941) 484-7804

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

F.W.C.P.T. is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

F.W.C.P.T. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities; and evaluating the quality of care that we provide. F.W.C.P.T., for example, may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

F.W.C.P.T. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, F.W.C.P.T. policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

F.W.C.P.T. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reason other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. F.W.C.P.T. will consider all such requests on a case by case basis, bu the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that F.W.C.P.T. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosures of your personal health information, please contact our practice administrator at the address listed below. You may also send written complaint to the US Department of Health and Human Services. For further information on F.W.C.P.T. health information practices or if you have a complaint, please contact the following person:

Greg B. Miller, P.T.
Administrator
256 S. Nokomis Ave., Ste. 2
Venice, Fl 34285
941-484-1939

Venice
256 S. Nokomis Ave., Ste. 2
Venice, FL 34285
PHONE: (941) 484-1939
FAX: (941) 484-7804

PATIENT INFORMATION ACKNOLEDGEMENT FORM

I have been provided with Florida West Coast Physical Therapy's Notice of Information Practices. I understand that Florida West Coast Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and adminstrative operations if I notify the practice. I also understand that Florida West Coast Physical Therapy will consider the requests for restriction on a case by case basis, but does not have to agree to requests for restriction.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Florida West Coast Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date