

SCARBOROUGH PHYSICAL THERAPY ASSOCIATES, P.A.

51 U.S. Route One, Scarborough, ME 04074

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SUMMARY OF "NOTICE OF PRIVACY PRACTICES"

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

- Scarborough Physical Therapy Associates (SPTA) maintains the privacy of certain confidential information about you known as "Protected Health Information" (PHI). Federal and State Law require SPTA to protect your PHI and provide this Notice of Privacy Practices ("Notice"). This Notice is attached to this Summary of Notice of Privacy Practices.
- The Notice describes SPTA's duties and the privacy practices regarding your PHI.
- The Notice describes how SPTA may use and disclose your PHI to carry out treatment, payment and healthcare operations and other purposes permitted by law.
- The Notice describes when an authorization is required to use or disclose your PHI and how you can revoke your authorization. The Notice also describes when SPTA may use or disclose your PHI without your authorization.
- SPTA is committed to protect the privacy of your PHI and have instituted policies and procedures to do this.
- The Notice describes your right to access, amend and receive an accounting of the disclosures of your PHI. The Notice describes your right to request restrictions on the use and disclosures of your PHI and the right to request that we use alternative means to communicate with you.
- If you have any questions, please contact our Privacy Official June Tait, at (207) 883-1227.

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Please read the attached Notice of Privacy Practices. Please sign this Acknowledgement.

I hereby acknowledge that I have received the Notice of Privacy Practices prepared by Scarborough Physical Therapy Associates, P.A.

Name of client or legal guardian: (please print) _____

Signature: _____

Date: _____

If not signed by the Patient, please provide the following information:

Print YOUR Name: _____ Relationship to the Patient: _____

SECTION 7: FOR FUTURE USE (This Section Not Applicable)

SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

CHECK HERE If this section does not apply and skip to Section 13.

Billing Agency Name and Address

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Legal Business Name (as Reported to the Internal Revenue Service)

Tax ID Number or Social Security Number (required)

"Doing Business As" Name (if applicable)

Billing Agency Address Line 1 (Street Name and Number)

Billing Agency Address Line 2 (Suite, Room, etc.)

City/Town

State

ZIP Code + 4

Telephone Number

Fax Number (if applicable)

E-mail Address (if applicable)

SECTION 9: FOR FUTURE USE (This Section Not Applicable)

SECTION 10: FOR FUTURE USE (This Section Not Applicable)

SECTION 11: FOR FUTURE USE (This Section Not Applicable)

SECTION 12: FOR FUTURE USE (This Section Not Applicable)