KINECI
HEALTH IN MOTION
PHYSICAL THERAPY • TRAINING • SPORTS

Welcome to Kineci! We are grateful that you have made a choice to join our physical therapy family and the start on your health improvement journey…

Please find enclosed the following documents:

- *Informed Consent (Please sign and return to us.)*
- *Prescreen Questionnaire (Please complete and return to us.)*
- *HIPAA and Privacy Disclosure (Please read and sign/return the first page to us.)*
- *…& the Medicare ABN Form- ONLY fill this out if you are over 65 & have Medicare - See next:*

Medicare ABN Form-

- *Box D= Testing, Evaluation, and Treatment*
- *Box E= Medicare does not pay for Testing, Evaluation, and Treatment*
- *Box F= Estimated cost $197*
- *Please check 'Option 2', sign the document, and return to us at your evaluation appointment.*

At Kineci, we believe you should be in charge of your healthcare decisions. Things you should know about Physical Therapy: You do NOT need a doctor's referral to see us. You have the right to go to any PT provider you choose. Only your best interests matter and its entirely your choice to make. We want you to be able to make these decisions so we do not direct bill through Medicare or insurance companies. We have you pay for services at the time of the appointment and will issue you a 'super bill' when you are ready to submit to your insurance company for reimbursement if your policy covers physical therapy. We will coordinate your care with your physician as you prefer.

If you have any questions, concerns, or need clarification you can call our clinic.
Kineci Health & Movement Center - Dr. Steve Politis, DPT
Phone: (805) 284-9449
22 West Mission Street, Ste B, Santa Barbara, CA 93101

We look forward to providing you with exceptional care in physical therapy, personal training, and continued service after your treatment plan. Please check out our website for information regarding licensure, certifications, services, programs, testimonials, and a synopsis on our Dr. Steve Politis, DPT.

https://kineci.com

We look forward to seeing you soon!

Michelle Voizin
Office Manager
Kineci with Dr. Steve Politis, DPT

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Informed Consent

Politis & Associates Physical Therapy, PC offers services ranging from physical therapy, fitness training, performance training, and bodywork. Your Physical Therapist is licensed by the state of California. Physical therapy involves the use of many different types of physical evaluation, testing, treatment, and training. At **Politis & Associates Physical Therapy, PC** , we use a variety of procedures, training, and modalities to help us to evaluate and improve your physical function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy and fitness/exercise training.

The physical response to a specific treatment or exercise varies from person to person. Thus, it is not always possible to accurately predict your response to a particular therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment will be, nor can we guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause pain or injury or may aggravate a previously existing condition.

Therapeutic exercises and movement are an integral part of most physical therapy treatment and fitness training plans. Movement and exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

You have the right to ask your physical therapist/ trainer what type of treatment he or she is planning based upon your history, diagnosis, symptoms and testing results. You may also discuss with your therapist/ trainer what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment/training at any time before or during your appointments.

Acceptance of Responsibility and Release of All Claims

I understand and agree that all aspects of my participation in physical therapy/training are and will be my sole choice. I accept full responsibility for my decision and for my own exertion, pacing, and safety. Anything and everything I do in physical therapy/training is and will be my choice. I will promptly tell my physical therapist/trainer about any concerns I may have and/or any changes in my health status.

I hereby release **Politis & Associates Physical Therapy PC** from any and all untoward consequences, claims, and/or causes of action that may, grow out of or be incident to the physical therapy/training services that I hereby authorize and accept, in so far as the law allows, provided that these services are performed with ordinary care and arise the best of their ability.

I acknowledge that my proposed program has been explained by Politis & Associates Physical Therapy, PC, to my satisfaction and all of my questions have been answered. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

_____ Date: _____
Patient/Client Signature M / D / Y

_____ Date: _____
Parent or Legal Guardian (if patient/client is a minor) M / D / Y

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Prescreen Questions

1. In the past 4 months, have you had any of the following? (check all that apply)

- o A serious injury
- o An accident
- o A fall
- o Surgery

2. Are you currently under any activity restrictions on the advice of a healthcare professional? **Y/N**

3. Do you have any heart, respiratory, or breathing/ conditions that limit your activity? **Y/N**

4. Please fill the blank to these 3 statements…

- o I have pain when doing _____
- o I'm unable to do _____
- o I'm not confident doing _____

Informed Consent

I understand the following:

- o It is my choice to participate in a movement screen that will take about 15-25 minutes to complete.
- o I will be asked to perform 12-15 movement patterns that simulate common physical activities.
- o I alone am responsible for my safety, comfort and pacing.
- o I may limit my movement or refuse to do any movements that I am asked to perform.
- o While participating, I am encouraged to ask about any questions or concerns that I might have.

Signature: _____ Date: _____ *M / D / Y*

Name: _____ Date of Birth: _____
First Middle Last *M / D / Y*

Address: _____
City State Zip

Email: _____ Phone: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship to Patient: _____

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Dr. Steve Politis, DPT - Kineci

Dear Patients:

We consider the privacy of your health information to be one of the most essential elements in our relationship with you. Our responsibility to maintain the confidentially of your health information is one that we take very seriously. We have taken the following steps to protect your privacy:

- We train our staff members on their responsibility to maintain the confidentially of your health information and hold them accountable for their actions.
- We do not sell your information to any organization.

Federal legislation concerning patient privacy requires health care providers, health insurance companies, and other health related organizations to bolster their privacy practices as of April 14, 2003.

Attached with this letter is our Acknowledgement Form and the Notice of Health Information Privacy Practices. We are pleased to provide this information to our patients and to comply with the privacy regulations of the federal Health Insurance Portability and Accountability Act (HIPAA).

1. Complete the Acknowledgment Form at the end of the Privacy Policy that states you have received a copy of the Notice and bring it with you when you come to our office for the first time.
2. Read the HIPAA Privacy Police and Notice of Privacy Practices attached and keep this for your records.

Thank you!
-Dr. Steve Politis DPT and Staff

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

_____
Printed Name

_____
Signature

_____
M / D / Y
Date

NOTE: Please print out this page, sign it, and bring it with you to your first appointment. The below privacy disclosure is for your personal records.

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HIPAA Privacy Policy for Kineci

PURPOSE

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these medical records to provide or enable other health care providers to provide quality medical care, to obtain payments for services provided to you as allowed by your payments/reimbursement through your medical health plan, and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed at the end of this document.

Details

A. This policy applies to all organization's employees, management, contractors, student interns, and volunteers.
B. This policy describes the organization's objectives and policies regarding maintaining the privacy of patient information.
C. This medical practice may collect health information about you and stores it in a chart and on a computer; this is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following services:

    a. Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
    b. Payment: We use and disclose medical information about you to obtain payment for the services we provide or for your reimbursement from your insurance provider. For example, we give your health plan the information it requires, if requested, before they will reimburse you for services rendered. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
    c. Health Care Options: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to reimburse for services rendered and paid by you out of pocket. We may also use and disclose information as necessary for medical reviews, legal services, audits, including fraud and abuse detection, compliance programs, business planning, and management.
    d. Appointment Reminders: We may use and disclosed medical information to contact and remind you about appointments. If you are not at home, we may leave this information on your answering machine, or in a message left with the person answering the phone.
    e. e.Sign in Sheet: We may disclose medical information about you by having you sign in when you arrive at our office. We may also call your name when we are ready to see you.
    f. Notification and Communication with Family: We may disclose your health information to notify and assist in notifying a family member, your personal representative, or another person responsible for your care, about your location, your general condition, or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a

disaster even over your objection if we believe it is necessary to respond to emergency circumstances. If you are unable or unavailable to agree/object, our health care professionals will use their best judgement in communication with your family and others.

g. Marketing: We may contact you to give you information about products or services related to your treatment, care coordination, or to direct or recommend other treatments or health related benefits/services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.
h. Required by Law: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect, or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
i. Public Health: We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection/ exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgement, we believe the notification would place you at risk or serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
j. Health Oversight Activities: We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by federal and California law.
k. Judicial and Administrative Proceedings: We may, and sometimes are required by law, to disclose your health information in the course of any administrative order. We may also disclose information about you in response to a subpoena, discovery request, or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
l. Law Enforcement: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person; complying with a court order, warrant, grand jury subpoena, and other law enforcement purposes.
m. m.Coroners: We may, and are often required by law, to discuss your health information to coroners in connection with their investigations of death.
n. Organ or Tissue Donation: We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
o. Public Safety: We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
p. Specialized Government Functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their custody.
q. Workers Compensation: We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by worker's compensation. We will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.
r. Change of Ownership: In the event that this medical practice is sold or merges with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request copies of your health information be transferred to another physician, medical group, or another physical therapy clinic.

When This Medical/Physical Therapy Practice May Not Use, or Disclose Your Health Information: Except as described in this Notice of Privacy Practices, this physical therapy clinic/practice will not use or disclose health information which identifies you without your written authorization. If you do not authorize this practice/clinic to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

A. Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures or your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

B. Right to Request Confidential Communication: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email or to your work address. We will comply with all reasonable requests submitted in writing which will specify how or where you wish to receive these communications.
C. Right to Inspect and Copy: You have the right to inspect and copy your health information, with limited exceptions. To access your medical information you want access too, and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California Law. We may deny your request to access your child's records because we believe allowing access would create reasonable or probable cause/substantial harm to your child, and you will have the right to appeal our decision. If we deny your request to access your health information, you will have the right to have them transferred to another provider.
D. Right to Amend or Supplement: You have the right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medial practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
E. Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosure provided to you or pursuant to your written authorization, or as described in paragraphs (1) Treatment, (2) Payment, (3) Health Care Operations, (6) Notifications and Communication with Family, and (16) Specialized Government Functions of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct payment identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
F. Right to a Paper Copy of this Notice: If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact Dr. Steve Politis, DPT.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current Notice posted in our reception area, and will offer you a copy at each appointment.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to Dr. Steve Politis, DPT, as listed on the final page of this Notice.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services- Office of Civil Rights
Hubert Humphrey Building, 200 Independence Avenue, S, W, Room 509F HHH Building
Washington, D.C. 20201

Kineci- Dr. Steve Politis, DPT
22 West Mission Street, Ste B, Santa Barbara, CA 93101
Phone: (805) 284-9449

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: