COPT
Comprehensive Orthopedic Physical Therapy

P: 732.846.9400
F: 732.846.9404

900 Easton Ave, Suite 22
Somerset, NJ 08873

info@coptnj.com
www.coptnj.com

PATIENT INFORMATION – *all information is REQUIRED*

Name _____Date of Birth ____ / ____ / _____Soc.Sec.#_____ - ____ - _____

Address _____City _____ State _____ Zip _____

Home Phone _____-_____- _____ Cell Phone _____-_____-_____Employer_____

Work Phone _____-_____ - _____ Email Address _____
How would like your appointments confirmed? ☐ Text ☐ Email ☐ Voicemail

In case of emergency, who should we contact? _____ Phone _____-_____- _____

PRIMARY INSURANCE

Insurance Name_____Phone #_____-_____-_____ Fax #_____-_____-_____

Insured Name _____Relationship to Patient _____

Insured Date of Birth ____ / ____ / _____ Insured Soc. Sec. # _____ - ____ - _____

ID # _____If auto or work accident, Claim # _____

SECONDARY INSURANCE

Insurance Name_____Phone # _____-_____-_____Fax #_____-_____- _____

Insured Name _____ Relationship to Patient _____

Insured Date of Birth ____ / ____ / _____ ID # _____ Group # _____

REFERRING PHYSICIAN

Name _____Phone # _____-_____-_____Fax #_____-_____- _____

Physician Address _____ City _____ State _____ Zip _____

ACCIDENT INFORMATION – *PLEASE PROVIDE POLICE REPORT IF AUTO ACCIDENT*

Type of accident: ☐ Work / ☐ Auto (☐ Driver / ☐ Passenger / ☐ Pedestrian) Injury Date ____ / ____ / _____

Where did accident occur (City, State) _____ Emergency Room: ☐ Yes / ☐ No

ATTORNEY INFORMATION

Name_____Phone #_____-_____-_____Fax #_____-_____ - _____

Address _____ City _____ State _____ Zip _____

SIGNATURE

I acknowledge receipt of the "**Notice of Privacy Practices**", which I have received at the time of this evaluation or previously.

_____ _____
Patient's Signature Date

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To ensure you receive a c omplete and thorough evaluation, please provide us with important background information. Please answer each question as accurately and as completely as you can. If you do not understand a question, please ask for assistance.

History of *Present* Condition

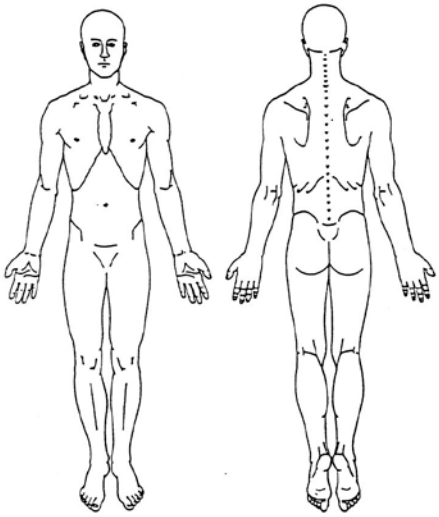
What are your symptoms?

_____

_____

_____

On the body diagram below, please indicate where your pain is located at the present time.



How would you rate the intensity of your pain on the scale below? *Check a number.*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 no pain 1 2 little 3 4 moderate 5 6 quite bad 7 8 severe 9 10 unbearable pain

When did your symptoms begin? *(Approx. date)*

_____

Which of the following BEST DESCRIBES how your injury occurred? *Check one*

☐ Lifting
☐ Work Injury
☐ A Fall
☐ Trauma
☐ Running
☐ MVA (Car Accident)
☐ During sports/recreation
☐ Overuse
☐ Degenerative process
☐ Unknown
☐ Other _____

Since onset are your symptoms getting:
☐ Better ☐ Worse ☐ Not Changing

Have you had similar symptoms in the past?
☐ Yes ☐ No

As the day progresses, do your symptoms:
☐ Increase ☐ Decrease ☐ Stay the same

Nature of your pain: *Check all that apply*
☐ Sharp ☐ Pins/Needles ☐ Radiating
☐ Throbbing ☐ Dull ☐ Numbness
☐ Aching ☐ Stabbing ☐ Burning
☐ Tingling ☐ Other_____

Is your pain:
☐ Constant ☐ Occasional / Intermittent

Does the pain wake you at night?
☐ Yes ☐ No
If yes, is it present…*Check one*
☐ While lying still
☐ When changing positions
☐ Both

What aggravates your symptoms? *Check all that apply*
☐ Sitting ☐ Going to/rising from sitting
☐ Lying down ☐ Walking
☐ Up/Down stairs ☐ Bending forward/backward
☐ Overhead ☐ Reaching behind back
☐ Standing ☐ Reaching in front of body
☐ Squatting ☐ Reaching across body
☐ Sleeping ☐ Coughing/Sneezing
☐ Stress ☐Taking a deep breath
☐Other_____

What relieves your symptoms? *Check all that apply*
☐ Sitting ☐ Stretching
☐ Heat ☐ Ice
☐ Rest ☐ Standing
☐ Walking ☐ Exercise
☐ Massage ☐ Medication
☐ Lying down ☐ Nothing
☐ Other_____

Have you had any previous treatment for this condition?
Check all that apply
☐ None
☐ Medication (oral)
☐ Massage therapy
☐Chiropractic_____
☐ Family Care Doctor_____
☐ Physical Therapy _____
☐ Specialist_____(type of specialty)

Have you had any of the following tests?
☐ X-Rays
*Date/Location*_____

☐ CT Scan
*Date/Location*_____

☐ MRI
*Date/Location*_____

☐ Other _____
☐ None

⇨ **Turn Over**

Medications

Please list any prescription medications you are currently taking. *(Pain pills, injections, skin patches)*

_____

_____

_____

_____

_____

_____

_____

_____

Are you currently taking any of the following over the counter medication? *Check all that apply*

☐ Aspirin ☐ Tylenol
☐ Corticosteroids ☐ Advil/Motrin/Ibuprofen
☐ Antihistamines ☐ Vitamins/Mineral Supplements
☐ Other _____

Height _____ft _____ in. **Weight** _____

How would you rate your general health?

☐ Excellent ☐ Average
☐ Good ☐ Fair
☐ Poor

Do you exercise outside of normal daily activities?

☐ 5+ days/wk ☐ 3-4 days/wk
☐ 1-2 days/wk ☐ Occasionally
☐ Zero

Exercise, Sports/Recreation consist of:

_____
_____
_____

Do you drink caffeinated beverages?

☐ No ☐ Yes

If yes, how many per day?

_____

Do you smoke?

☐ No ☐ Yes

If yes, how many packs per day?

_____

What is your stress level?

☐ Low ☐ Medium ☐ High

For Females: Is there a possibility you may be pregnant?

☐ No ☐ Yes

Are you currently seeing any other health care providers other than the physical therapist?

_____
_____
_____

Past Medical History

Have you ever been diagnosed with any of the following conditions? *Check all that apply*

☐ Cancer ☐ Multiple Sclerosis
☐ Depression ☐ High Blood Pressure
☐ Arthritis ☐ Kidney Problems
☐ Asthma ☐ Blood Disorders
☐ Head Injury ☐ Parkinson's Disease
☐ Osteoporosis ☐ Stomach Problems
☐ Diabetes ☐ Circulation/Vascular Problems
☐ Stroke ☐ Epilepsy/Seizures
☐ Heart Problems ☐ Infectious Disease
☐ Broken Bone ☐ Thyroid Problems
☐ Allergies _____
☐ Other _____

Surgical History

Please list any past surgeries / procedures you have had along with the date.

Surgery **Date**

_____
_____
_____
_____
_____

Family History

Has anyone in your immediate family (parents, siblings) ever been treated for any of the following?

☐ Diabetes ☐ Cancer
☐ Heart Disease ☐ Arthritis
☐ Osteoporosis ☐ High Blood Pressure
☐ Stroke ☐ Psychological Condition
☐ Other _____

Work History

Occupation:

_____

☐ Full Time ☐ Part Time
☐ Self Employed ☐ Retired
☐ Student ☐ Homemaker
☐ Unemployed ☐ Other _____

Physical Activities at work *Check all that apply*

☐ Sitting ☐ Standing
☐ Phone Use ☐ Repetitive Lifting
☐ Computer Use ☐ Heavy Lifting
☐ Driving ☐ Heavy Equipment Operation
☐ Other _____

Are you currently receiving or seeking disability benefits for this condition?

☐ Yes ☐ No

Signature_____ **Date** _____/_____/_____

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OFFICE POLICIES

We welcome you as a patient and appreciate the opportunity to provide you with the quality care and individualized attention we are known for. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we require you read and sign prior to any treatment. All patients must complete registration and insurance forms before seeing the therapist.

A Note Regarding Insurance Carriers

_____ *(Initial)* Some insurance companies pay fixed rate for physical therapy procedures while others pay a percentage of the charge. This information is verified for each patient prior to their first visit by a member of our staff as a courtesy. **This verification is not a guarantee of benefit or payment.** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, but as a service to all our patients, we will accept an assignment of benefit and bill your insurance company directly for you. Please remember that we do not make up the terms to your insurance plan, we only carry it out.

_____ *(Initial)* By signing below you authorize payment of all benefits to *Comprehensive Orthopedic Physical Therapy* for services rendered to yourself or others for whose medical benefits you are responsible for. Once all payments are received, you will receive a bill for any portion that the insurance carrier deemed as your responsibility.

_____ *(Initial)* If you are unable to pay in full, we are willing to make arrangements for regular payments upon receipt of a bill from us. If you fail to make a payment and cannot contact us immediately, please be advised that all overdue accounts past 30 days after completion of treatment will be handled through a collection agency to reduce administrative costs and provide quality care to our patients. There is a rebilling fee of $25.00 for each bill resubmitted and an interest rate of 1.5% per month on all overdue accounts past 30 days. If your account is referred for collection, a collection fee of 25% will be added to the outstanding amount owed to the office along with additional reasonable attorney's fees and court filing fees if necessary.

_____ *(Initial)* Your signature below also authorizes the release of any and all medical records as requested by your physician, insurance company, or attorney when appropriate. Regular reports are expected to your referring physician as an update of your progress in physical therapy.

Special Notes regarding PIP, Motor Vehicle, Worker's Comp

- Personal injury cases are handled in the same manner.
- Please be aware that for standard PIP coverage, there is a $250 deductible and 20% co-insurance until $5000 and the limit on medical expenses is $250,000.
- If your plan is different, it is your responsibility to know what your portion is. Auto insurance policies have changed a lot over the past few years and so did the coverage. If your deductible is more or if your medical expense limit is less than the standard, your will be responsible for the difference.
- Having an attorney does not mean that you are always covered for medical expenses. Please note that if the claim is disputed or denied for any reason, you are fully responsible for the balance.

Social Media Permission Disclaimer

_____ *(Initial)* I grant permission to COPT and its representatives the right to use, reproduce and publish photographs, testimonials, and/or video content ("Content") that may contain my image, likeness and/or voice. I understand that this Content may be used in publication, press releases, marketing materials, advertisement (both digital and print), websites (including social media sites), and/or other uses. I agree and understand that I shall neither be compensated for the Content nor receive attribution for the Content. This authorization is continuous, and only I may withdraw this authorization through specific, written rescission. I hereby release COPT from any liability of any kind related to the use, reproduction, or publication of the content.

Missed or Cancelled Appointments

_____ *(Initial)* As a courtesy to all of our patients, we require a 24 hour advance notification for all cancellations. A $50 fee would be assessed to No Show Appointments. Advance notice allows someone else to reserve that time that was set aside for you. Please be courteous and responsible.

We look forward to building a successful relationship with you that lasts a lifetime!
I have read, understand, and agree to these policies.

Signature:_____ **Date:** _____

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Comprehensive Orthopedic Physical Therapy
Cancellation / No-Show Policy

Please Read Carefully

Comprehensive Orthopedic Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with an assigned therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

- **If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled.**
- **A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE.**
- **Failure to show up for an appointment ("NO SHOW") without notifying us will result in a $50 fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments. You will receive one courtesy call after your first No Show, any additional No Shows will result in removal from any future scheduled appointments. You will need to call to resume and reschedule your appointments for physical therapy. The accumulation of 3 No Show appointments will result in discharge from the therapy program.**
- **At week's end, ALL PATIENTS, regardless of insurance/third party payor, will be charged a $50 CANCELLATION FEE for each no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.**
- **No fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.**
- **All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor. Worker's Compensation and Personal Injury patient's documents of any missed or cancelled appointments are forwarded to your case manager and primary care doctor. This could jeopardize your claim and prolong or stop any benefits you may be entitled to.**
- **Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.**

Please DO NOT CANCEL if you are feeling worse and believe the treatment is not working. Keep your appointment and discuss any changes with your therapist. Please understand that your pain will probably fluctuate as your course of treatment progresses.
Please DO NOT CANCEL if you are feeling better. Keep your appointment in order to progress your plan and prepare for discharge.

When you don't show as scheduled, three people are hurt. You, because you don't get the treatment you need; the therapist, who now has a space in his/her schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All of the staff at Comprehensive Orthopedic Physical Therapy appreciates your anticipated adherence and cooperation with this policy. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities. We appreciate the opportunity to provide you uncompromising care. Thank you for your consideration of our staff and other patients.

_____ _____/_____/_____
Patient Acknowledgement/Signature Date

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HEALTH QUESTIONNAIRE

Patient Name: _____

Parent/Guardian Name: _____

I acknowledge and understand that there is an increased risk that COVID19 can be transmitted in any place of public accommodation, including a physical therapy clinic. I have been informed that my therapist desires to protect the safety of the clinic, patients, staff and other individuals who enter the premises.

As a precondition to rendering treatment to myself as the patient, or my child as the patient, I have confirmed that I/we have no symptoms associated with COVID19, including fever, shortness of breath, dry cough, running nose or sore throat, and that I/we have not within the past 10 days traveled by airplane, or had close contact with a person who has confirmed positive for COVID19 or is presumptive positive for COVID19.

I hereby consent to the treatment proposed by the physical therapist for myself as the patient, or for my child as the patient, and agree to notify the office in the case I/we are subjected to the following within 10 days of any treatment I receive here:

- have symptoms associated with COVID19, including fever, shortness of breath, dry cough, running nose or sore throat
- plan to or have traveled by airplane
- had close contact with a person who has confirmed positive for COVID19 or is presumptive positive for COVID19

Printed Name: _____

Have you been fully vaccinated? (2 doses of Pfizer/Moderna or 1 dose of J&J) ☐ Yes / No ☐

If Yes, what was the date of your 2nd shot of Pfizer/Moderna or 1 dose of J&J? _____

Signature: _____

Date: _____

COVID-19 PANDEMIC TREATMENT AND PREVENTATIVE PROCEDURES

NOTICE AND ACKNOWLEDGEMENT OF RISK

Our goal at Comprehensive Orthopedic Physical Therapy is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease and The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources and while the main goal of the practice wants to protect the safety of the clinic, patients, staff and other individuals who enter the premises, we need to ensure you are aware of the additional risks of contracting COVID-19 through physical therapy. The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms, yet still be highly contagious.

Our team members are taking extra precautions in addition to normal protocol to maintain a safe and healthy treatment environment. This includes, but is not limited to employee education on appropriate sanitation of the treatment environment, proper hand hygiene, use of face masks, and a requirement to stay home when showing symptoms of illness. However, due to the frequency and timing of visits by other physical therapy patients and the characteristics of the virus, there is still a risk of you contracting the virus simply by being in the clinic, as with anywhere.

We are also making the following accommodations to limit the assimilation of individuals in the clinic and limit potential exposure:
-Asking patients to wash their hands/use hand sanitizer upon entering the clinic
-Requiring that patient's wear face masks
-Reducing the number of physical therapists and patients who are in the clinic at one time
-Providing the option of telehealth physical therapy
-We are asking that family members do not wait in the waiting area

For your safety, the safety of other patients and the safety of our team members, we ask that you reschedule your appointment if you:
-Have any of the COVID19 symptoms listed on the CDC website

- have symptoms associated with COVID19, including ***fever, shortness of breath, dry cough, running nose or sore throat***
- plan to or have traveled by airplane
- been in close proximity (less than 6 feet) at a gathering of ten or more persons

-Have been in close contact with someone with known or suspected Coronavirus (COVID19)

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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

The terms of this Notice of Privacy Practices apply to Comprehensive Orthopedic Physical Therapy, LLC and each of its subsidiaries, affiliates, and entities managed or controlled by Comprehensive Orthopedic Physical Therapy, LLC, including the corporate office and its employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Comprehensive Orthopedic Physical Therapy.

We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to Comprehensive Orthopedic Physical Therapy, LLC, 900 Easton Ave. Suite 22, Somerset, NJ 08873.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved In Your Care: With your written or oral agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Comprehensive Orthopedic Physical Therapy, 900 Easton Ave. Suite 22, Somerset, NJ 08873.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- any purpose required by law.
- public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- to workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION

Access to Your Personal Health Information: You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. For more information, please ask the front office person or individual responsible for medical records.

Amendments to Your Personal Health Information: You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. For more information, please contact the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Personal Health Information: You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. Requests can be given to the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing to, Comprehensive Orthopedic Physical Therapy, LLC, 900 Easton Ave. Suite 22, Somerset, NJ 08873. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Workers' Compensation: For patients whose medical treatment is covered under a state workers' compensation program, please note the following: Disclosure of your protected health information (PHI) for purposes of providing treatment and obtaining payment under the state's workers' compensation is governed by the state workers' compensation regulations and procedures. Therefore, we are not obligated to secure a written authorization as otherwise required by HIPAA in order to disclose your PHI for workers' compensation purposes, nor may you restrict our use or disclosure of your PHI for workers' compensation purposes. Written consent to use or disclose your PHI may be required pursuant to our internal policies and/or state workers' compensation program rules in order to process your claims. Failure to provide any required written consent may result in your financial liability for medical services and supplies.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact our office at, Comprehensive Orthopedic Physical Therapy, LLC, 900 Easton Ave. Suite 22, Somerset, NJ 08873.