

2140 Bellmore Ave  
Bellmore, NY 11710  
(516) 586-5533  
Fax 516-586-5531

Sid Jacobson JCC  
300 Forest Drive  
East Hills, NY 11548  
(516) 626-8787  
Fax: 516-626-8789  
POOL



Sherrie Glasser MS PT, Owner/Director

333 East Shore Rd  
Manhasset, NY  
11030  
(516) 466-9730  
Fax: 516-466-1228

800 East Gate Blvd  
Garden City, NY 11530  
(516) 745-8050  
Fax: 516-745-6766  
POOL

745 Route 25A  
Rocky Point, NY 11778  
(631) 849-6000  
Fax (631) 849-6002  
POOL

## **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 CAREFULLY.*

IF YOU HAVE ANY QUESTIONS ABOUT THIS POLICY, YOU MAY CONTACT OUR OFFICE.

**Metropolitan Physical Therapy's Legal Duty:** It is the legal duty of Metropolitan Physical Therapy to protect the confidentiality of your personal health information (PHI). We are required to provide you with this notice which outlines policies and procedures.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

Metropolitan Physical Therapy, hereafter referred to as the Practice, uses your PHI in order to provide treatment to you, to be able to obtain payment for your treatment, to perform administrative activities within the Practice, and for being able to determine the quality of care that is provided to you. PHI is all the personal information that can identify you: your name, address, telephone number, social security number, health policy number, etc.. For example, we may use your PHI to call you to remind you about an appointment or to contact you insurance information for payment, speak to your doctor about your program, or just call you into the treatment area from the waiting room.

The practice may use your PHI without prior authorization when we are to do so by law, if there is a public health concern, if you have a communicable disease, if we believe that there is abuse or neglect, for research studies, for legal proceedings, for law enforcement, if a crime occurs in the Practice's office, if an emergency occurs, to funeral directors and coroners, for military activity and national security, and for worker's compensation.

It is policy of Metropolitan Physical Therapy to get a signed authorization from you prior to releasing your PHI. You have the right to either agree or object to the release of your information. If you agree and sign the written authorization, you have the right to take back the authorization at a later date if you chose to. If you are not actually present, or unable to agree or disagree to the disclosure of information, the Practice can then use its professional judgment to decide if the disclosure is in your best interest.

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**PATIENT'S INDIVIDUAL RIGHTS:**

You have the right to inspect and ask for a copy of your PHI at any time. You have the right to ask us to make changes or corrections in your information. The Practice does not have to comply with your request. You have the right to file a disagreement with the Privacy Officer.

You may request a list of all the disclosures that we have made of your PHI after 4/14/2003 for any reason other than treatment, billing, or administrative activities of the practice.

You also have the right to ask in writing that the Practice not disclose your PHI except when authorized b you, required by law or in the case of an emergency. You may also request that your PHI is not disclosed to family members or friends that may be involved in your care. The Practice will consider all requests, but is not required to agree or act on them.

You have the right to have confidential information sent to you at an alternative locations or by means other than the postal service.

You have the right to obtain a copy of this notice.

**CONCERNS AND COMPLAINTS:**

If you feel that your privacy rights have been violated at any time or you do not agree with how your PHI is being disclosed, you can contact our privacy officer at the address listed below. The Practice will not retaliate against you for filing complaints. You can also contact the Secretary of Health and Human Services.

**Metropolitan Physical Therapy  
800 East Gate Blvd.  
Garden City, NY 11530  
516-745-8050  
Fax: 516-745-6766**

The terms of this notice may change at any time. A copy of the revised notice will be posted in the office in an easily accessible area and will be provided upon your request. This notice was published on May 1, 2003 and becomes effective as of April 14, 2003.



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2140 Bellmore Ave  
Bellmore, NY 11710  
516-586-5533  
Fax 516-586-5531  
Fax: 516-794-8758

Roslyn JCC  
300 Forest Drive  
East Hills, NY 11548  
516-626-8787  
Fax: 516-626-8789

### Patient Acknowledge of Receipt of Privacy Practices Notice

This is to acknowledge that I have received and reviewed Metropolitan Physical Therapy's Notice of Privacy Practices. If I have any questions, I can contact the practice at 516-745-8050.

In addition to the doctors I have provided Metropolitan Physical Therapy with, my medical records may also be released to the following people.

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Print name

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Signature

# Metropolitan Physical Therapy

800 East Gate Blvd

Garden City, NY 11530

Phone: 516-745-8050 Fax: 516-745-6766

Sherrie Glasser, M.S., P.T.

## Attendance & Cancellation Policy

Metropolitan 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 a reserved time slot for each patient and have a therapist work with you to assume your treatment. Your attendance of the planned treatment regimen is paramount to your recovery.

If you cannot make an appointment we request that you ATTEMPT to notify us no later than the prior day before 4 pm so we can reschedule.

All cancellations and no shows will be documented in your medical records and reported to your physician as well as your insurance company.

If you accumulate 2 no shows or cancel without sufficient notification you will be charged a \$60 fee for each episode. The therapist might also place you on a **“schedule based on availability list”**, meaning that you have to call for an open appointment on each day you want to come and we will try to accommodate you at that time.

I have read and understand the Attendance Policy

\_\_\_\_\_  
Patient or Parent Signature

\_\_\_\_\_  
Date

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Fax: 516-745-6766  
POOL

745 Route 25A  
Rocky Point, NY 11778  
(631) 849-6000  
Fax (631) 849-6002  
POOL

Dear Patient,

We are updating our records to make sure that we send progress notes to all of your doctors. We'd appreciate it if you could take a few minutes and give us the names and phone numbers of all your doctors that you would want us to send your progress notes to. Please fill this out and hand it to the receptionist.

Thank you for your time.

Sherrie Glasser, PT, MS

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Dear Patient,

Since physical therapy is a way of managing symptoms of pain and swelling, the use of electrical stimulation may be incorporated into your treatment.

The electrodes that we use are a self-adhesive electrode that can be re-used and are intended for single patient use for hygienic purposes. Unfortunately, your insurance company does not cover the cost of these electrodes; therefore you will be responsible for the one time charge of \$4.00 - \$10.00 depending on how many electrodes are used for your condition. THIS CHARGE WILL BE EXPECTED AT THE TIME OF SERVICE.

Please be assured that your therapist will properly evaluate and determine the necessary use of electric stimulation to enhance the benefit of physical therapy.

Thank you for your understanding.

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Metropolitan Physical Therapy

Signature \_\_\_\_\_

Date \_\_\_\_\_

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## ASSIGNMENT OF BENEFITS

I \_\_\_\_\_ authorize my insurance company to assign the benefits over to Sherrie Glasser, MS,PT. Please make all payments directly to her office. Keep this on file for future bills submitted by her.

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Patient Signature

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Thank you for your time.

Sherrie Glasser, PT, MS

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## MEDICARE PATIENTS

Have you received any Home Care services in the last six months?

No \_\_\_\_\_, Yes \_\_\_\_\_ (please check)

If yes, have you been discharged from Home Care and when? \_\_\_\_\_

Also, if you start receiving any home care services while you are receiving treatment from Metro PT, you must inform us immediately, as you cannot have both treatments at the same time.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**\*\*\*Reception: If yes, notify KB immediately.\*\*\***



Sherrie Glasser, MS, PT  
Director

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(Pool)

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MEDICARE TERMS & CONDITIONS FOR PHYSICAL THERAPY

I, \_\_\_\_\_, understand that Metropolitan Physical Therapy participates in Medicare and therefore will be billing at the Medicare fee schedule. I am aware that I am responsible for meeting my deductible and for my co-insurance. If you wish to continue physical therapy when your Medicare benefits exhaust, you will be responsible for our private fee.

I have also advised Metropolitan Physical Therapy that my condition being treated is not related to a work and/or on the job injury, nor is it due to any motor vehicle accidents.

It at any time during treatment, there is a problem with payment, e.g., notification of benefits denial, etc., please notify the office manager immediately.

I understand that although my insurance has been verified, there is no guarantee of payment. If, for any reason, they deny payment, if benefits exhaust or policy cancels, or my home health agency has not discharged me, I am responsible for all monies owed. I also understand it is my responsibility to be aware of all policy provisions and to adhere to them.

In further consideration of the services rendered, I agree to waive the defense of statute of limitations in any action commenced against me to recover any sums due pursuant to this or any other agreement I may have with Sherrie Glasser, M.S., P.C.

If this account shall be placed in the hands of an outside attorney for collection, the responsible party agrees to pay all costs of collection, including reasonable attorneys' fees not to exceed 20% of the unpaid balance, together with necessary court costs and disbursements.

If you are unable to keep your appointment, please give the office 24-hour cancellation notice.

I have read the above and agree to the Terms and Conditions.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_