STAR REHABS (Physical Therapy) 120 W 7th St, Ste 200, Plainfield, NJ

Patient Name: ______________________

Patient Number: ____________________

Authorization Form

Authorization for use or Disclosure of Protected Health Information. Required by Health Portability and accountability act. 45 CFR. Parts 160;164

Patient Name: ____

I authorize the release of my medical records and/or copies of such from:

________________________________ Physician		________________________________ Referring Physician
________________________________ Address	and/or	________________________________ Address
________________________________ City, State, Zip		________________________________ City, State, Zip

And request that they are transferred to Star Rehabs Inc. (Physical Therapy),

I authorize Star Rehabs Inc. to release following information from my medical records:
☐ Itemized Bill ☐ All Records ☐ Specific Records ______________ to ____

My medical records may be released to my:

☐________________________ Spouse

☐________________________ Child(ren)

☐________________________ Attorney

☐ Information may not be released to anyone.

I authorize my medical records to be sent via:
☐ E-mail ☐ Fax ☐ Mail

Assignment of Benefits	Initial _______

I hereby instruct and direct ____________________________________ insurance company to pay by check made out and mailed to:

STAR REHABS, 120 W 7th St, Ste 200, Plainfield, NJ

If my current policy prohibits direct payment to this practice, I hereby also instruct and direct my insurance company to make the check to me and mail as follows: ______________________________[Patient's Name]
C/o ***STAR REHABS, 120 W 7th St, Ste 200, Plainfield, NJ***

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of this assignment shall be considered as effective and valid as the original.
- I also authorize the release of any information pertinent to my case to my case to any insurance company, adjuster, or attorney involved in this case.
- I authorize Star Rehabs to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

HIPPA NOTICE OF PRIVACY PRACTICES	Initial ________

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.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physical therapist's practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

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Patient Name: ______________________

Patient Number: ____________________

Patient Authorization | Office Policies

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Star Rehabs. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Other examples might include: employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision accreditation, certifications, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintain compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states' public health department.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You may revoke this authorization, at any time, in writing, except to the extent that your provider or the providers practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the following rights under the federal privacy standards regarding the health information that we maintain about you. These rights are as follows:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend and submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your complaint in writing. We will not retaliate against you for filing a complaint.

Star Rehabs Inc Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

No Show / Cancellation	Initial _________________

We realize circumstances might cause you to miss a scheduled appointment; however, to provide the best care and service to each patient, we ask that you notify us 24 hours in advance to cancel your appointment. We will be more than willing to reschedule your appointment for a different time on the scheduled day OR within 24 hours.

Please be aware that failure of proper notification could result in a No Show/Cancellation fee of $25.

We value our patient/therapist relationships and will do everything we can to accommodate you. Your communication and compliancy are not only very much appreciated but will help you (and others) achieve a positive outcome.

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I have read and understand all above authorizations and policies and I agree to them.

X___________________________   ____   __________________

Patient/Legal Guardian Signature   Patient Name   Date