

Beach Physical Therapy, PC

138 Montauk Highway, East Moriches, New York 11940 | Tel: 631.874.6860 | Fax: 631.874.6861

Notice of Privacy Practices Acknowledgment

By my signature below, I hereby acknowledge receipt of this Notice of Privacy Practices, and I acknowledge that Beach Physical Therapy, PC will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations.

I understand that I may request in writing that Beach Physical Therapy, PC restricts how my private information is used or disclosed. I also understand that in providing treatment, submitting bill- ing, and conducting healthcare operations, Beach Physical Therapy, PC has my permission to disclose my protected health information to the following:

_____	Primary Care / Family Doctor
_____	_____ (relationship to me)
_____	_____ (relationship to me)
_____	_____ (relationship to me)
_____	_____

Print Patient's Name

Signature of Patient or Parent / Guardian

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Patient Authorization and Guarantee

RELEASE OF INFORMATION

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Beach Physical Therapy, PC to my physician(s), as well as any organization responsible for payment of my account, and any legal representative invoiced in my litigation. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize that the payment of authorized benefits be made directly to Beach Physical Therapy, PC for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

CONSENT OF TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of Beach Physical Therapy, PC.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by Beach Physical Therapy, PC, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and/or deductible, which I am fully responsible for paying. Although Beach Physical Therapy, PC will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify Beach Physical Therapy, PC of any changes in my insurance coverage while receiving physical therapy.

MEDICARE

I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release this to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

HIPAA PRIVACY

I hereby certify that I read and understand the HIPAA privacy statement. I acknowledge I was given an opportunity to receive a copy of the privacy statement at this time or any time in the future.

I, _____ by signing this document, acknowledge my consent to the above.

Signature: _____ Date: _____