HIPAA CONSENT FORM

I give this practice / clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice / clinics Notice of Privacy Practices, (for a more complete description of uses and disclosures) before signing this consent.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice / clinic is not required to agree to the request. If the practice / clinic agrees to my requested restrictions, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____ _____

Patient's Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to signing this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office.

Signature below is only acknowledgement that you have received the Notice of Privacy Practices.

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

PATIENT HISTORY QUESTIONNAIRE

Patient Name (Nombre): _____

(Last Name) (First Name)

Street Address (Direccion): _____

City: State: Zip Code:

Phone # (Telefono) Home: Cell: Work:

Sex (Sexo): M / F Date of Birth (Fecha de Nacimiento): _____ S.S. # (Seguro Social): _____

Nature of Accident: (Accidence) ☐ Automobile (Auto) ☐ Slip & Fall (Caida) ☐ Work Related (Trabajo) Other: (Otros) _____

Date of Accident (Fecha de Accidente): _____

Insurance Company Name: _____ Phone #: _____

Address (Direccion): _____

Claim # (Número de Reclamo): _____ Policy # (Número de Póliza): _____

Attorney's Name (Nombre de Abogado): _____ Attorney's Phone # (Telefono de Abogado): _____

Attorney's Address (Direccion): _____

Health Insurance (Plan Medico): _____ Phone #: _____

Address: _____

Subscriber ID #: _____ Group #: _____

Name Insured: _____ Insured Date of Birth: _____

BENEFITS

I hereby authorize payment directly to this office for professional service rendered, and I shall be personally responsible for any unpaid balance to the doctor. I hereby authorize the attending doctor to release any information concerning my examination or treatment that may be necessary of either medical care, legal documentation or processing application for financial benefits.

BENEFICIOS

Yo autorizo pago directo a esta oficina por servicios profecionals recividos, soy personalmente responsible por servicios medicos no pagados, autorizo a el doctor a reveler cualquie information que consierna mi consulta o tratamiento resividos ya sea mi seguro, abogado, otros medicos.

_____ _____ _____

Patient's Signature (Firma de Paciente) **Guardian Signature** (Tutor) **Date** (Dia)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I am hereby requesting that you release any and all medical records regarding any treatment I have received from your facility to:

_____

Yo autorizo la liberazion de los expedients médicos por la presente solicito que libera a todos mi expedients médicos con respect a cualquier tratamiento que recibido de sus instalaciones de

_____

_____ _____

Patient's Signature (Firma) Date

_____ _____

Patient's Name (Please Print)
Nombre del Paciente (Deletreado)

Date of Birth (Fecha de Nacimiento)

ASSIGNMENT OF BENEFITS

Patient Name _____ Date of Birth _____

Patient's Address _____

Date of Loss _____ Insurance Company _____

Name of Policyholder _____

Policy Number _____ Claim Number _____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to: _____ , hereafter referred to as "the medical provider" to pursue and obtain payment from the above mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

2. I, assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. However, upon consent of both parties, same shall be revocable.

3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.

4. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider and monies due on my account, or, have same deducted from any settlement made on my behalf.

5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider with (5) five days of receipt of same.

6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

7. In the event that the insurance carrier and/or the vendor designated by the insurance carrier does not accept my assignment, or my assignment is challenged for being invalid, I execute this limited/special power of attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the carrier in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name.

Patient's Signature _____ Date _____

Patient's Name (Please Print) _____ Witness _____