# 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

# MEDICAL PROVIDER'S LIEN

_____

Patient's Name

_____

Date of Accident

_____

Provider's Name

I herby authorize undersigned provider to furnish my attorney _____ with a full report of my examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize my attorney (previously listed) to pay directly to my provider such sums as may be due and owing them for professional services rendered to me by reasons of this accident and by reasons of any other bills that are due them and to withhold such sums from my settlement, judgement or verdict as may be necessary adequately to protect bills of my provider. I hereby further give a lien on my case to my provider against any and all proceeds of any settlement, judgement or verdict which may be paid to my attorney (previously listed) or me as the result of the injuries for which I have been treated in connection herewith.

I fully understand that I am directly and fully responsible to my provider for all professional bills submitted by same for services rendered to me and that this agreement is made solely for my provider's additional protection and in consideration of provider awaiting payment.

PATIENT hereby irrevocably directs his/her attorney, if any to pay the full amount owing for services rendered by PHYSICIAN, or any balance thereof immediately upon receipt of an invoice from PHYSICIAN from monies received from PATIENT'S attorney(s) as a result of any compromise, settlement, arbitration, mediation, litigation or any other collection activities by PATIENT or PATIENT'S attorney(s). This agreement shall constitute an irrevocable assignment and lien on any monies collected or received as a result of the condition for which PHYSICIAN treats PATIENT.

_____ _____

Patient's Signature Date

_____ _____

Provider's Signature Witness

# 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)

## APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

IMPORTANT:

1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW. YOU MUST COMPLETE AND SIGN THIS FORM
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

| DATE | OUR POLICYHOLDER | DATE OF ACCIDENT | FILE NUMBER |
|---|---|---|---|
| | | | |

TO: _____
CLAIM DEPT.

| YOUR NAME | PHONE NO. | HOME | BUSINESS |
|---|---|---|---|
| YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH - - | SOCIAL SECURITY NO. | |

| DATE AND TIME OF ACCIDENT - - | A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE) |
|---|---|---|

BRIEF DESCRIPTION OF ACCIDENT

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐
NAME OF INSURANCE COMPLANY _____

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES ☐ NO ☐ IF YOUR ANSWER IS YES COMPLETE THE REST OF THIS FORM. IF NO SIGN HERE AND RETURN THIS FORM TO US.

**SIGNATURE:** _____ DATE: _____

DESCRIBE YOUR INJURY

| WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐ | DOCTOR'S NAME AND ADDRESS |
|---|---|

| IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN: IN-PATIENT? ☐ OUT-PATIENT? ☐ | HOSPITAL'S NAME AND ADDRESS | |
|---|---|---|
| AMOUNT OF MEDICAL BILLS TO DATE: $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ | AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐ |

| DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐ | IF YES, AMOUNT LOST TO DATE $ | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $ |
|---|---|---|

| IF YOU LOST WAGES: | DATE DISABILTY FROM WORK BEGAN | DATE YOU RETURNED TO WORK |
|---|---|---|

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER:

| | YES | NO |
|---|---|---|
| 1. ANY WORKMEN'S COMPENSATION LAW? | ☐ | ☐ |
| 2. EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE? | ☐ | ☐ |
| 3. MEDICARE? | ☐ | ☐ |

IF YES, AMOUNT
$ _____
☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
|---|---|---|---|
| | | | |
| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
| | | | |
| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

**ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.**

**SIGNATURE:** _____ DATE: _____

**APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION (CONT.)**
**- AUTHORIZATION / SIGNATURE PAGE -**

_____

## AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THE INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: DATE:

## AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: DATE:

## AUTHORIZATION TO EXTEND TIME TO SCHEDULE A PHYSICAL EXAMINATION FOR DECISION POINT REVIEW

**(OPTIONAL)**

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE TO TAKE UP TO 14 DAYS AFTER RECEIPT OF NOTICE FROM MY HEALTH CARE PROVIDER (RATHER THAN THE 7 DAYS NORMALLY REQUIRED) FOR SCHEDULING A PHYSICAL EXAMINATION IF ONE IS NEEDED IN ORDER TO MAKE A DETERMINATION REGARDING THE MEDICAL NECESSITY OF TESTS OR TREATMENTS UNDER THE CURE DECISION POINT REVIEW PLAN.

SIGNATURE: DATE:

# 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 _____