44th Street Health & Wellness
535 Fifth Avenue
Suite 906
New York, NY 10017 P. 212-973-8299 F. 212-937-3304 www.44healwell.com

HIPAA PRIVACY NOTICE EFFECTIVE APRIL 14TH 2003

This note describes how medical information about you may be used and disclosed and how you may obtain access to this information. This office has always recognized the importance of privacy; this new federal law formalized practices that have been followed routinely.

Background: In 1996, Congress recognized the importance of privacy standards and as a part of the Health Insurance Portability and Accountability Act abbreviated as HIPAA, ordered that a set of rules be established to control how the health information is used and disclosed, as maintained by doctors, hospitals and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information as do similar protections already enacted for bank accounts, credit cards and even video rentals.

- By Law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows for prescriptions to be called into the pharmacy and for scheduling of surgery in a facility or hospital.
- Additionally, none is needed in the course of carrying out health care operation such as assessments or in communication with your insurance carrier for payment-related issues or for incidental uses such as announcing a name in a waiting room or the use of sign-in sheets.
- However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or government entity without your written consent.
- Specific authorization is required to disclose protected information in non-routine circumstances such as to your employer or for use in marketing a product for you.
- Medical information about you may be related for research and public health uses as long as you are not individually identified.
- You are guaranteed access to view your medical records and you may amend the recorded information if you believe it to be incomplete or inaccurate.
- You have a right to know when and to whom your information was related.
- You may suggest additional restrictions with regard to certain uses and disclosures as you wish.
- Portions of this Notice may be modified as long as you are notified.
- Should you believe that your privacy rights have been compromised you may report the violation without penalty to you, to this office or to the Secretary of Health
- The law requires you to acknowledge receipt of this Notice. This has been included on the signature release on your registration form.

Patient Signature: _____ Date: _____

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UNIFORM ASSIGNMENT OF BENEFITS

I (print name) _____ assign, transfer and set over to the above named facility sufficient monies and/ or benefits which I may be entitled to from the government agencies, insurance carriers or others who are financially liable for the cost of care and treatment rendered to myself or my dependent.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the above named facility to release any and all records, medical history, services rendered or treatments given to me at any dependent for the purpose of review, investigation or evaluation of any claim submitted by my insurer.

GUARANTEE OF PAYMENT

I understand that I am financially responsible for any and all charges for services of treatment rendered to the above named patient. I agree to pay the above named facility their usual and customary fee for services rendered unless I request and accept the Financial Hardship Agreement. I also agree that if any government agency, insurance carrier or others remit payment to me, I agree to immediately turn over full payment to the above named facility.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Anesthesia services provided are billed separately from procedural services. I hereby authorize the above entities to furnish information to the insurance carriers concerning my procedures and I do hereby assign to the physicians all payment for medical services rendered to myself or my dependents. Furthermore, in the event that my insurance company denies payment or pays less than the amount billed, I authorize 44th Street Health & Wellness or their designees to pursue an appeal on my behalf.

Patient Signature: _____ Date: ___/___/___

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FINANCIAL HARDSHIP AGREEMENT

By virtue of my signature set forth below, I hereby request that my doctor and institutional provider reduce their usual and customary charges in order to allow me to receive care required by my current health care condition.

I represent and warrant that my financial status is such that I would be unable to receive diagnostic and treatment services if usual and customary charges were applied to the services required by my condition.

I recognize and acknowledge that this Agreement to reduce usual and customary charges is undertaken for my benefit, that this is dependent on my financial status as of the date of this Agreement, that it will result in a fee arrangement distinct from the one usually in place for the services in question and that the arrangement represents a confidential agreement entered into by the parties for my sole and exclusive benefit.

In light of the foregoing, I hereby agree to the following:

1. I will not seek reimbursement for the services rendered to me under this arrangement from any insurance company, employer, welfare program, government entitlement program (Medicare or Medicaid), Workers' Compensation program or other third-party payor.

2. If any third party payor responsible for all or part of the payment due as a result of services rendered under this Agreement contacts me, I will notify such payor of this arrangement and the reduced fee achieved as a result of the Agreement.

3. If the financial circumstances which cause me to qualify for financial hardship under this Agreement change, I will immediately notify my doctor and institutional provider in order to allow them to determine whether my financial status will then allow me to pay usual and customary charges for the services which I receive that date forward.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Witness Signature: _____

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NOTICE TO PATIENTS

Please carefully review the information contained in this Notice:

1. You have the right to choose the provider of your physical therapy services. This Notice is intended to assist you in making a fully informed decision about your health care.

2. This Notice serves to disclose that Ahmed Ghanem is an employee of 44th Street Health & Wellness. Our Practice wants you to know that you do have the option to use an alternative physical therapy provider if you so choose.

3. For more information about alternative physical therapy providers, please feel free to ask us. If requested, we will provide you with the names and addresses of alternative physical therapy providers in the area.

4. If you choose to be referred for physical therapy to an alternative provider outside of the Practice, please know that you will not be treated differently by your physician or by any employee of *44th Street Health & Wellness*.

If you have any questions concerning this Notice, please feel free to ask your physician or any representative of the Practice.

ACKNOWLEDGEMENT: I have read this "Notice to Patients" form, and I understand by signing this Notice that the Practice has disclosed the employment relationship that exists with respect to the physical therapy services provided by Ahmed Ghanem.

Dated this _____ Day of _____ , 20 _____

_____

Signature of Patient Name of Patient (Printed)

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We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

INFORMATION

Last Name: _____ First Name: _____ Date of Birth: _____

Email: _____ SS# _____ Gender: □ M □ F Married: □ Y □ N

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Preferred contact method □ Home Phone □ Work Phone □ Wireless Phone □ Email

How did you hear about us? _____

(If someone referred you here, please write down their name so we can thank them.)

Address: _____

Address 2: _____

City: _____ State: _____

Zip: _____

Insurance Company: _____

Member Name: _____ Member ID # _____

Employer: _____

Your relationship to Member: □ Self □ Spouse □ Child