

HIPPA POLICIES AND PROCEDURES

Privacy policies statement/HIPAA: You will have an opportunity to review and question our privacy policies statement at your request. This statement will outline our policies that protect your privacy. We will release your personal health information for billing purposes to be reimbursed for services rendered. You may request (in writing) to prevent us from doing so without penalty or cessation of your care. If you exercise this right, you will be responsible for the costs of your therapy, and it will be your responsibility to submit claims to your insurance carrier for reimbursement of those costs.

Authorization for release of information: I hereby authorize the *Center for Spine and Sport Rehab* to furnish records from any treatments, photocopies of such records and/or information, and excerpts from such records to the following:

- attending physician,
- the attending physician's associates, and/or consultants,
- third-party payer (whether an insurance company, government agency, or self-insured employer),
- any utilization review organization (whether sponsored by the clinic, an insurance company, government agency, or self-insured employer),
- any transferee health care facility and/or agency

for the purposes of obtaining payment for services rendered while under clinic care, performing utilization review, and/or post care and treatment. If this is a work-related injury, I authorize the *Center for Spine and Sport Rehab* to provide my employer with any and all needed information related to my condition. Finally, if further care from another therapist, physician, or specialist were needed I authorize the release of my records to such parties.

Financial information: I guarantee payment of all physical therapy charges for treatment provided to the below named patient to the *Center for Spine and Sport Rehab*. I understand that I am financially responsible for all charges including but not limited to all co-payments, deductibles, and expenses not covered by my insurance. In the event that industrial or auto insurance exhausts or refuses to pay, I authorize the *Center for Spine and Sport Rehab* to bill my health insurance. I, the undersigned, give permission to release information to third party carriers and do assign all insurance benefits for treatments to be paid directly to the *Center for Spine and Sport Rehab* and request that this assignment remain on file with my insurance carrier. I understand that the unpaid balance is due in full upon completion of care, and that there is a monthly finance charge of 1.5% applied to the unpaid balance after 30 days from discharge. If legal action is taken against this account I agree to pay for all reasonable legal fees associated with this action.

Consent to treatment: I, knowing that I have a condition requiring diagnosis, treatment, or related care do hereby consent to such care; physical therapy examinations, procedures, interventions, and/or treatment as deemed necessary by physical therapists, their assistants or aides. I further acknowledge that no guarantees have been made to me as to the results of such care, physical therapy examinations, procedures, and/or interventions.

I have read, understand, and agree to abide by the above stated policies and procedures. I certify that a copy of this agreement shall be valid as the original.

Print name: _____

Signature: _____ **Date:** _____