Notice of Privacy Practices and Financial Policy

Consent and Statement of Financial Responsibility

I agree to the terms and policies presented and hereby request and authorize **Hulst Jepsen Physical Therapy, Inc.** to treat me and/or my dependent. I certify that I and/or my dependents have insurance coverage and assign payment of benefits directly to **Hulst Jepsen Physical Therapy, Inc.** for all physical therapy services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Should the insurance company issue payment directly to me for these services, *I will pay the full amount issued*, to Hulst Jepsen Physical Therapy, Inc. within 15 days from my receiving payment.

I authorize the use of this signature on all insurance submissions. I also authorize the release, for medical and/or billing purposes, all information acquired in the course of my and/or my dependent child's treatment.

Privacy Practices

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. We use this information, referred to as your health or medical record, as a basis for planning your care and treatment, a means to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information and to make more informed decisions when authorizing disclosure to others. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.
In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our office. You also may send a written complaint to the U.S. Department of Health and Human Services. Our office can provide you with the appropriate address upon request. We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

I acknowledge receipt of this notice of privacy practices. I understand that I may request additional restrictions on the use and disclosure of my protected health information or for additional confidential treatment of communications.

Release of Protected Health Information

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Emergency Contact Info

Name: _______________________ Phone Number:___________________ Relationship:______________

By signing below, you authorize Hulst Jepsen Physical Therapy, Inc. and approve that you have received notification of Privacy Practices, to release protected health information and to the individual(s) above, and financial assignment and release. If you do not want us to release your location in our office to anyone, it is your responsibility to inform us. (Please note: refusal to sign this form does not change financial responsibility for payment in any way)

x____

Signature of patient or personal representative Date

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Printed Name of Patient Relationship to Patient