

**HIPAA PATIENT PRIVACY NOTICE**

**AUTHORIZATION FOR RELEASE OF INFORMATION, INFORMED CONSENT AND APPOINTMENT OF PATIENT REPRESENTATIVE**

- **I HEREBY AUTHORIZE THE RELEASE** of information from my medical records for the purpose of financial reimbursement for services rendered. I request that payment be made directly to THE ABOVE AGENCY. **I certify that the information given by me is correct**, and that this case is subject to Peer Review Organization quality review in the event of a written complaint.
- **I CONSENT TO RELEASE OF MY MEDICAL RECORDS** to be reviewed by authorized representatives of Medicare, Medicaid, Blue Cross/Blue Shield of Michigan and/or my private insurance carrier(s). In addition, I authorize the records to be reviewed for audits within the agency.
- **I CONSENT TO THE RELEASE OF MEDICAL INFORMATION** to physicians, hospitals, extended care facilities or community resources as needed.
- **I CONSENT TO THE RELEASE OF PATIENT NAME** to physicians, hospitals, and other source(s) that has referred me to THE ABOVE AGENCY (Thank you cards).
- **I AUTHORIZE THE STAFF OF THE ABOVE AGENCY** to carry out all procedures as ordered by my physician.
- **AUTHORIZATION OF PATIENT REPRESENTATIVE TO MEDICARE:** In the event that my claim for benefit payment is denied, I appoint **THE ABOVE AGENCY** to act as my representative in connection with my claim under Title XVIII (Medicare coverage). I authorize this agency to make or give any request, to present evidence, obtain information and to receive notice in connection with my claim in asserted right wholly in my stead, with no fee incurred.  
I understand that Medicare will pay 80% of these charges after the deductible and co-insurance (if applicable). I will pay 20% co-insurance and deductible

**WORKER’S COMPENSATION, AUTO & OTHER LIABILITY INSURANCE CLAIMS AUTHORIZATION**

*United Physical Therapy & Rehabilitation Inc.* assumes your right or the right of your beneficiaries, to recover money from another person, insurance company or organization. You grant us your right to recover services tendered to you, together with interest and cost, from the person, insurance company or organization. You grant us a lien on all money that you or your beneficiaries recover through settlement, verdict or judgment. You agree to inform us when you hire an attorney to represent you and to inform your attorney of our right under this certificate. You are required to do whatever is necessary to help us enforce our right of recovery, including but not limited to, executing delivering instruments and paper necessary to secure those rights.

I hereby authorize *United Physical Therapy & Rehabilitation Inc* to bill my insurance company and receive the payment directly from them. I agree to pay co-pays & deductibles issued by my insurance. For non-covered services, I agree to pay charges upon receipt, unless arrangements have been agreed to by **THE ABOVE AGENCY** and patient/guardian.

**CONSENT FOR CARE**

I (or my legal guardian or parent) authorize *United Physical Therapy & Rehabilitation Inc.* to provide Medical Care reasonable to today’s standards.

I have received and reviewed this document in its entirety. I understand the rights and protections offered to me by the HIPAA provisions. Lastly, I understand that this document and the protections it offers are for my benefits.

\_\_\_\_\_  
**Patient/legal guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**UPT & Rehab employee signature**

\_\_\_\_\_  
**Date**

Are you currently enrolled in any HMO?

**Please circle Yes or No**

Are you covered under an employer group health plan based on your current employment or the current employment of your spouse?

**Please circle Yes or No**

\*\*\* If yes is noted on either of the above questions, please make sure that the information is correctly recorded on the admission sheet.