HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date

INSURANCE VERIFICATION

Primary_____
Secondary_____

PROVIDER: Lisa Schroeder, PT, OCS

IN-NETWORK:_____ MD:_____

RX DATE_____ DX:_____

PATIENT:_____ID#:_____

POLICY HOLDER:_____ HOLDER SS#:_____

GROUP#:_____DATE OF BIRTH_____

INS. CO.:_____PHONE #:_____

INS. ADDRESS:_____EFFECTIVE DATE:_____

_____

CLAIM #:_____INSURANCE REP NAME:_____

_____COVERAGE OF USUAL & CUSTOMARY CHARGES

DEDUCTIBLE AMOUNT:_____DEDUCTIBLE MET:_____

LIMITATIONS OF TREATMENT:_____

_____

PRE-AUTHORIZATION:_____ AUTHORIZATION NUMBER:_____

COMMENTS:_____

_____

DATE VERIFIED:_____BY WHOM:_____

THE PATIENT AGREES TO PAY $_____ CO-PAY PER VISIT. DEDUCTIBLE MAY ALSO BE DUE IF NOT SATISFIED FOR THE CURRENT YEAR.

If you have any questions regarding the above benefits and/or information, please ask for clarification.
YES, I HAVE READ AND UNDERSTAND THE ABOVE STATED INFORMATION.

_____ _____

Patient signature **Date**

Lisa Schroeder, PT **Phone: (310) 628-4885**

Patient Name:_____ Insured Name:_____

Address:_____ Phone No: Work:_____

_____ Home:_____

_____ Cell:_____

Date of Birth: _____/_____/_____ Age:_____ SS#_____

Sex: (Male)_____ (Female)_____ Marital status: S M D W other

Referring Physicians Name:_____ Phone #:_____

Date of Injury or onset of Pain: _____

Accident details:_____

INSURANCE: circle one Reg Insurance (BC/BS, Cigna, etc) Work Comp PI (Pers Inj) MC (add secondary below or write none)

PRIMARY INSURANCE:_____ Subscriber Name:_____

Insurance Phone Number:_____ Subscriber ID No:_____
Or claim number

Ins Claims Address:_____

SECONDARY INSURANCE:_____Subscriber Name:_____

Insurance Phone Number:_____ Subscriber ID No:_____

Ins Claims Address:_____

If Personal Injury/Legal:
Attorney Name:_____ Phone no:_____

Name of W/C claim adjuster:_____ Phone No:_____

Diagnosis:_____
make sure diagnosis is clear to us

Copy of MD Prescription: be sure all info is legible_____ Referring Dr. NPI#:_____

COMMENT:_____
_____
_____
_____

Authorization to Release Information and Assignment of Benefits: I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and any other health plan to Schroeder Physical Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient's Signature:_____ Date:_____