

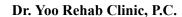


25 Rockwood Pl. #220, Englewood, NJ 07631 Tel: (201) 408-5151 | Fax: (201) 408-5353

Patient Name 성함			Date 날짜		
Date of Birth 생년월자			Sex 성별		
Address 주소					
SSN 소셜넘버			Occupation 직업		
Phone No. 전화번호			Emergency No. 비상전화번호		
Email 이메일주소					
Who referred you to our office? 저희 병원을 어떻게 알고 오셨나요? □ Patient (지인) □ Advertising/Search (광고 및 구글서치) □ Other (기타):					
Insurance Company 보험회사	y				
Date of Accident 사고날짜			Claim No. 클레임번호		
Name of Adjuster 사고담당자			Phone No. 전화번호		
I hereby authorize direct payment of medical benefits to Dr. Jason Yoo (Dr. Yoo Rehab Clinic, P.C.), also permit a copy of this authorization to be used in the place of the original. I hereby authorize Dr. Jason Yoo (Dr. Yoo Rehab Clinic, P.C.) to release any information required in the course of my examination and treatment. I hereby authorize any physician, hospital, or medical facility to provide the information on my medical history to Dr. Jason Yoo (Dr. Yoo Rehab Clinic, P.C.). I also understand that I am financially responsible for all the charges whether or not paid by my insurance.					
Date:		Patient's Sig	mature: X		

서명

날짜





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You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subjected to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction request and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your Protected Health Information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if anv. of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your primary rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14. 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Name (Print):	Date:	Signature:	X



Dr. Yoo Rehab Clinic, P.C.

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Patient Name:	
Date of Birth:	
Assignment of Benefits	
I request that payment of authorization benefits be marked for any service furnished the patient listed above by puthese payments to Dr. Yoo Rehab Clinic; Jason Yoo, I file an appeal on my behalf for any denial of payment services and care provided. If my health insurance plant Clinic, I agree to forward to Dr. Yoo Rehab Clinic all I for the services rendered by Dr. Yoo Rehab Clinic and it	roviders, and I assign my right to receive M.D. I authorize Dr. Yoo Rehab Clinic to at and/or adverse determination related to will not direct payment to Dr. Yoo Rehab health insurance payment, which I receive
I authorize Dr. Yoo Rehab Clinic or any holder of me listed above to release to my health insurance plan subenefits or the benefits payable for related services.	
X	
Patient / Person legally responsible	Date
Other Health Insurance	
I certify that the insurance information that I have provi that no other coverage or insurance exists.	ded is accurate, complete, and current and
X	
X Patient / Person legally responsible	Date
Patient Responsibility	
I acknowledge that I am responsible for all charges for above which are not covered by my health insurance payment under my health insurance plan. To the extrinsurance plan, I acknowledge that I am responsible agree to pay all charges not covered by insurance. I furt reimburse Dr. Yoo Rehab Clinic; Dr. Jason Yoo, M.D. that may be incurred by Dr Yoo Rehab Clinic; Dr. Jason	e plan or for which I am responsible for ent no coverage exists under my health for all charges for services provided and her agree that, if permissible by law, I will for all costs, expenses, and attorney's fees
X	
Patient / Person legally responsible	Date