Dr.Yoo 재활통증병원
DR YOO REHAB CLINIC

Dr. Yoo Rehab Clinic, P.C.
25 Rockwood Pl. #220, Englewood, NJ 07631
Tel: (201) 408-5151 | Fax: (201) 408-5353

Patient Name 성함	Michael Jackson	**Date** 날짜	07/23/2004
Date of Birth 생년월자	01/12312	**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			
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: 07/23/2004
날짜

Patient's Signature: X _____
서명

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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): Michael Jackson **Date:** 07/23/2004 **Signature:** X

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Patient Name: Michael Jackson

Date of Birth: 01/12312

Assignment of Benefits

I request that payment of authorization benefits be made on my behalf to Dr. Yoo Rehab Clinic for any service furnished the patient listed above by providers, and I assign my right to receive these payments to Dr. Yoo Rehab Clinic; Jason Yoo, M.D. I authorize Dr. Yoo Rehab Clinic to file an appeal on my behalf for any denial of payment and/or adverse determination related to services and care provided. If my health insurance plan will not direct payment to Dr. Yoo Rehab Clinic, I agree to forward to Dr. Yoo Rehab Clinic all health insurance payment, which I receive for the services rendered by Dr. Yoo Rehab Clinic and its healthcare providers.

I authorize Dr. Yoo Rehab Clinic or any holder of medical information about me or the patient listed above to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services.

X _____ 07/23/2004

Patient / Person legally responsible **Date**

Other Health Insurance

I certify that the insurance information that I have provided is accurate, complete, and current and that no other coverage or insurance exists.

X _____ 07/23/2004

Patient / Person legally responsible **Date**

Patient Responsibility

I acknowledge that I am responsible for all charges for services provided to the patient listed above which are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. To the extent no coverage exists under my health insurance plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance. I further agree that, if permissible by law, I will reimburse Dr. Yoo Rehab Clinic; Dr. Jason Yoo, M.D. for all costs, expenses, and attorney's fees that may be incurred by Dr Yoo Rehab Clinic; Dr. Jason Yoo, M.D. to collect those charges.

X _____ 07/23/2004

Patient / Person legally responsible **Date**