Authorizations to Release Information and Billing Disclosures

Starr Spine Physical Therapy and Wellness, LLC

3966 First St Unit A; Grove City, OH 43123 (614) 594-2400

Billing Disclosure/Statement of Financial Responsibility

Starr Spine Physical Therapy and Wellness, LLC appreciates the confidence that you have in selecting us to provide your rehabilitative needs. The service you have elected to participate in implies your financial responsibility. This responsibility obligates you (the patient) to ensure payment in full of your fees. As a courtesy, we will verify your 3rd party payer/insurance coverage and bill your insurance carrier on your behalf unless you are receiving out-of-network (OON) coverage. In an OON coverage situation, you may be billed entirely for each session and payment will be due the same day as therapy service is provided. Patients then will receive a bill for them to submit to their insurance carrier/payer for personal reimbursement. Regardless of in-network or out-of-network, you, the patient, are ultimately responsible for payment of your bill.

You are responsible at the time of service for paying any co-payment and for any deductible as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount that is not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account balance is not paid in full and referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks, and most major credit cards. Payments can be made at the clinic or mailed to the address on your statement.

I have read the above billing disclosure and financial responsibility statement for Starr Spine Physical Therapy and Wellness, LLC on behalf of me or as a representative or guardian of the patient listed below. I certify that the information provided regarding my rehabilitative care at this clinic is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any appropriate and relevant benefits directly to Starr Spine Physical Therapy and Wellness, LLC. I agree to pay Starr Spine Physical Therapy and Wellness, LLC the full and entire amount of all bills incurred by me or the patient named below, if applicable, and any amount that is due after payment has been made by my insurance carrier.

Patient or Legal Guardian Signature:____

Patient Name (and Legal Guardian if applicable)________________________________ Date:__________

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<u>Notice of Privacy Practices</u>

The Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program, which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

As required by "HIPAA", we have provided and posted the <u>Notice of Privacy Practices</u> to explain how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

I understand and have been provided, (see brochure at front desk), with a <u>Notice of Privacy Practices</u> that provides a more complete description of information uses and disclosures. If I have any further questions in regard to the Privacy Practices, I can contact the privacy officer at Starr Spine Physical Therapy and Wellness, LLC.

I authorize Starr Spine Physical Therapy and Wellness, LLC to release relevant information regarding my care as needed per HIPAA to appropriate third parties, including referring physician and other healthcare professionals involved with my care, as well as agencies to secure payment for provided services.

Patient or Legal Guardian Signature:____

Patient Name (and Legal Guardian if applicable)___________________________________ Date: ____________

Authorizations to Release Information and Billing Disclosures

Authorization to Release Health Information to Other Individuals

There may be occasions when it is necessary to share information about you with an individual directly, such as a family member or friend, for your care. Please list those individuals with whom we may speak and those that you do not wish us to disclose information about you and your care.

Note: Please mark a person(s) as **EMERGENCY CONTACT** by writing **EC** in *RELATIONSHIP* Section.

Those who may receive information about me and my care:

NAME	RELATIONSHIP	PHONE NUMBER

Those who may NOT receive information about me and my care:

NAME	RELATIONSHIP	PHONE NUMBER

I authorize Starr Spine Physical Therapy and Wellness, LLC to release relevant information regarding my care as needed to only those approved individuals listed. I understand it is my responsibility to notify Starr Spine Physical Therapy and Wellness, LLC in a timely manner if this list changes and that Starr Spine Physical Therapy and Wellness, LLC is not responsible for any unwanted disclosures or their consequences prior to that notification.

Patient or Legal Guardian Signature:____

Patient Name (and Legal Guardian if applicable)__________________________________ Date:_____________

Authorizations to Release Information and Billing Disclosures

AUTHORIZATION TO USE RECORDING DEVICES

In conjunction with my care, I authorize the use of recording devices, including, without limitation, a camera and/or mobile device to record videos and/or images for the purposes of enhancing my care. I understand that such images and/or recordings may be stored in my patient record and deleted from the recording device in compliance with HIPAA law. In addition, I authorize the transmittal of such recording device videos and/or images to my rehabilitation provider and/or the treating physician through secure email and/or text message. I acknowledge that such videos and/or images will only be used or disclosed for treatment purposes, and that my rehabilitation provider will not further use or disclose such videos and/or images for any other purpose without my written authorization.

Patient or Legal Guardian Signature:____

Patient Name (and Legal Guardian if applicable)________________________________ Date:_______________

Authorizations to Release Information and Billing Disclosures

Patient Communication Policy and Consent

We will communicate with you through various methods when you are not in our clinic (herein referred to as "out-of-clinic") if/when we cannot speak to you directly. Automated appointment reminders are usually sent via text, voicemail/phone call, or e-mail. Home Exercise Programs are typically sent via e-mail and are accessible on your phone if you choose to use the home exercise app. General information also may be sent to you through e-mail, text, or voicemail. All e-mails will be encrypted to enhance security and protection of your protected health information (PHI), yet mobile apps may not be encrypted. You may decline to receive such communication (i.e. Opting-out) or state your preferred methods (i.e. Opting-in) to receive out-of-clinic communication as mentioned).

If you (patient is referred to herein as "you," "I," "me," "my," "yourself," and "your") choose to sign this consent and opt-in to receive such communication, Starr Spine Physical Therapy and Wellness, LLC (herein also referred to as "Provider") will not impose a separate charge for these messages. Fees and/or restrictions may be imposed upon you for receiving notifications from us as per your wireless carrier contract. Please contact your wireless carrier about such fees and/or restrictions prior to providing your consent herein to such notifications from Provider. It is important to note that certain communications, including, without limitation e-mail and text messages, which may contain your PHI, are not invariably secure since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

You have the right to revoke this consent by providing written notice of revocation to the Privacy Officer at Provider. The revocation will become effective on the day the Privacy Officer receives the revocation of the consent, and any prior notification from Provider will not be subject to such revocation of the consent.

Authorizations to Release Information and Billing Disclosures

Consent for Patient Communication

I hereby consent to receive (i.e. opt-in) from Starr Spine Physical Therapy and Wellness, LLC any notifications and information, which may include my PHI, by the following methods of communication that I indicate below, with a full understanding of the risks involved with such communications from Provider. I agree to assume all responsibility for informing Provider in writing of any changes to any of the methods of communications that I indicate below. I will ensure that the methods of communication that I indicate below are secure, with password protection used where applicable. I further agree that Starr Spine Physical Therapy and Wellness, LLC shall not be held liable for any unauthorized disclosures of my PHI to a third party through any of the methods of communication that I authorized below or for any fees and/or restrictions that may be imposed upon me for receiving notifications from Provider.

If Opting-In, Please Provide Corresponding Contact Information with Your Preferred Method of Message Delivery for ***Appointments*****:**

Voicemail: ________________________________

Text Message: _____________________________

E-mail Address: ____

If Opting-In, Please Provide Corresponding Contact Information with Your Preferred Method of Message Delivery for ***Home Exercise Programs***:

Text Message: _____________________________

E-mail Address: ____

If Opting-In, Please Provide E-mail Address or Preferred Phone Number for ***General Correspondence***:

Voicemail: ________________________________

Text Message: _____________________________

E-mail Address: ____

Opt-out of receiving out-of-clinic communications from Provider entirely or partially per omissions in the above sections (Please Circle Answer.): Yes, for opting-out entirely No, to opt-in as per above

Patient or Legal Guardian Signature:____

Patient Name (and Legal Guardian if applicable)______________________________ Date:_________________