Starting Smart

NEW PATIENT INFORMATION

PATIENT NAME

DATE OF BIRTH

ADDRESS

CITY, ZIP CODE

PHONE

ALT. PHONE

EMAIL

EMERGENCY CONTACT

RELATION TO PATIENT

EMERGENCY CONTACT PHONE

REFERRING PHYSICIAN NAME

REFERRING PHYSICIAN PHONE

HOW DID YOU HEAR ABOUT US?

WHAT ARE YOUR CONCERNS ABOUT YOUR CHILD?

INSURANCE INFORMATION

POLICY ID NUMBER

GROUP NUMBER

POLICY HOLDER

DATE OF BIRTH

INSURANCE PROVIDER

PROVIDER PHONE NUMBER

We strive to provide you with the most accurate benefit information. However, this is not a guarantee of coverage. Should you feel that the information provided to you may be in error we encourage you to contact your insurance carrier. Co-Payment amounts are specified by the terms of the member's benefit agreement and are the patient's responsibility at the time of service. I hereby authorize the above information as accurate. Any remaining unpaid balance will be my responsibility.

STARTING SMART, LLC
3359 N. Seminary Ave. #1 | Chicago, IL 60657
Phone: (248) 819-0771 | Fax: (773) 697-4611

PATIENT HEALTH INFORMATION CONSENT FORM

The patient understands and agrees to allow Starting Smart, LLC to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.

The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections, please keep in mind that when requesting records a fee may apply. The patient may request to know what disclosures have been made. Should any restrictions be submitted in writing, our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Starting Smart, LLC has the right to refuse care.

HIPAA PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned. At the same time, the Privacy Rule recognizes circumstances arise where health information may need to be shared to ensure the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others. The Rule is carefully balanced to allow uses and disclosures of information—including mental health information—for treatment and these other purposes with appropriate protections.

In this guidance, we address some of the more frequently asked questions about when it is appropriate under the Privacy Rule for a health care provider to share the protected health information of a patient who is being treated by Starting Smart, LLC. We clarify when HIPAA permits Starting Smart, LLC providers to:

- Communicate with a patient's family members, friends, or others involved in the patient's care
- Communicate with family members when the patient is an adult
- Communicate with the parent of a patient who is a minor
- Consider the patient's capacity to agree or object to the sharing of their information
- Involve a patient's family members, friends, or others in dealing with patient failures to adhere to medication or other therapy

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CONSENT FOR TREATMENT

I authorize and consent to any Therapist for Starting Smart, LLC to perform Physical Therapy evaluation and treatments. I certify that no guarantee or assurance has been made as to the results that may be obtained. I have read and understand the above. I understand that I may stop treatment at any time.

CANCELLATION

If you cancel less than 24 hours from time of appointment, a $75 cancellation fee will be charged.

INSURANCE INFORMATION

I authorize a release of any medical and/or patient information needed to determine benefits or benefits for related services to any insurance company, any other third party payer, state medical assistance agency and/or any other governmental private payer responsible for paying such benefits. I agree to pay for all my charges not covered.

I hereby give my consent to Starting Smart, LLC use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physical therapist. I also understand that I will not be able to revoke this consent in cases where the physical therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Starting Smart, LLC.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

PRINTED NAME _____ DATE _____

SIGNATURE _____

NOTICE OF PRIVACY PRACTICES

I have received the attached: Starting Smart, LLC Notice of Privacy Practices and HIPAA.

CHILD'S NAME _____ CHILD'S DATE OF BIRTH _____

PRINTED NAME OF PARENT / LEGAL GUARDIAN _____ RELATIONSHIP TO CHILD _____

SIGNATURE OF PARENT / LEGAL GUARDIAN _____ DATE _____

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