INCREASE YOUR V

Wellness & Health

ASSIGNMENT OF BENEFITS / HIPAA / FINANCIAL RESPONSIBILTY

HIPAA and Authorization to Release Information

I have received a copy of IncreaseYourV, LLC Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully.
I understand that IncreaseYourV, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact IncreaseYourV, LLC at any time to obtain a current copy of the Notice of Privacy Practices.

Financial Responsibility

I have requested medical services from IncreaseYourV, LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Authorization to Release Information

I hereby authorize IncreaseYourV, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan, to Issue payment check(s) directly to IncreaseYourV, LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

This is to authorize you to release any information regarding my condition and care to My Insurance Carrier(s), or Other Health Care Providers or Referring Physicians directly associated with my care. I "do" authorize IncreaseYourV, LLC and staff to provide and/or discuss my care and medical needs with my immediate family; spouse; children; parents.

Patient Name: (Print) _____ **Date:** _____

Signature of Patient/Legal Representative: _____

COMPLETE THIS SECTION ONLY IF YOU "DO NOT" WANT INFORMATION DISCUSSED OR RELEASED TO SPECIFIC INDIVIDUALS: I "DO NOT" authorize Affiliated Physical Therapy to provide and/or discuss my care and medical needs with:

Name(s): _____

Signature of Patient/Legal Representative: _____ **Date:** _____