Moorestown
INTEGRATIVE WELLNESS
703 East Main St. Suite B
Moorestown, NJ 08057
info@moorestownwellness.org
844-244-0842

Assignment of Benefits

I, _____, authorize assignment of all health insurance benefits which I am entitled to including Medicare, Medigap, BCBS or any other commercial insurance to be paid to Moorestown Integrative Wellness Inc. for services rendered, unless other arrangements have been made.

I _____, understand that I may be financially responsible to Moorestown Integrative Wellness Inc. for charges not covered by my health insurances carrier(s).

I _____, agree to re-pay Moorestown Integrative Wellness Inc. any money I receive from my health insurance carrier for services provided to me for which I have not paid to Moorestown Integrative Wellness Inc.

I have read and agree with the above:

Print name _____ Signature _____

Date _____

HIPAA Compliance Patient Consent Form

This ***Notice of Privacy Practices*** outlines how we may use or disclose protected health information (PHI). It also describes your rights under the health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, you confirm that you have received and reviewed our ***Notice of Privacy Practices****.*

Your Rights Regarding Your Health Information

You have the right to restrict how your PHI is used or disclosed for treatment, payment or healthcare operations. While we are not required to agree to your request, if we do, we will honor the agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

You may request to receive your health information through alternative means or at a different location than usual.

You have the right to access, review, and obtain a copy of your health records.

You may request that we amend your health records. While we are not obligated to accept your request, if we deny it, you will receive a written explanation and information about how to formally disagree with the decision.

You may request a written list (an "accounting") of certain disclosures we have made of your PHI.

You have the right to request a paper copy of our **Notice of Privacy Practices** at any time

How We Use and Disclose Your Health Information

We may disclose your health care information without your written consent in the following ways:

- For treatment, payment, and healthcare operations: We may share your PHI with other healthcare providers within our practice. to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
- We can use and share your health information to bill and get payment from health care plans
- To comply with State Workers' Compensation Laws
- In respond to lawsuits and legal proceedings.
- In situations required by law, including reporting of:
    - Suspected or known child abuse or neglect
    - Suspected or known sexual abuse of a child

- Adult and Domestic abuse
- Judicial or administrative proceedings (i.e. you are ordered here by the court)
- Serious threat to health or safety (i.e. “Duty to Warn”)

Our responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Please sign below to indicate that you have reviewed and understand our Notice of Privacy Practices and HIPAA Compliance Patient Consent Form

I have read and agree with the above:

Print name_____ Signature _____

Date _____

RELEASE OF INFORMATION

I, _____, authorize the release of all medical information necessary to determine the extent of third party coverage and for the purpose of obtaining payment for services rendered. I authorize the use of this signature on all insurance submissions whether manual or electronic. This assignment will remain in effect until insurance information changes or is revoked in writing by the patient or authorized representative. I have read and agree to the above. _____

Signature of Patient OR Authorized Representative

_____ Printed Name of Patient OR Authorized Representative