INFINITY OF CARE

Patient's name: _____ M F

SS# _____ Date of Birth _____ Marital status _____

Address:_____

_____

Home Phone: _____Work Phone: _____Cell: _____

Email: _____ Preferred method of contact: ☐ SMS ☐ Email ☐ Phone

Insurance Co._____ PCP _____

Policy _____ Group _____Cl#_____

Attorney name _____ Phone _____

If Accident Date_____State ____Type: MVA Fall Work Other

Fill out this portion only if you are not Primary Insurance Holder

Insured's Name: _____ M F

Date of Birth _____ SS# _____Relation to Patient: _____

Address:_____

Insurance Authorization and Assignment:

I authorize release of my medical information to my insurance company, attorney, employer or other interested party as necessary: I certify that I have reported with regard to insurance and financial responsibility is correct. I authorize and request payment of medical benefits to be made directly to the Infinity of Care Inc. I agree that this authorization will cover all medical cervices rendered until such authorization is reworked by me. I agree that photocopy or facsimile of this form may be used in the lieu of the original. I understand that I am responsible for all balances resulting from deductibles, coinsurance, co-pays, delays caused by inaccurate information and/or non-covered services regardless of the outcome of this case.

Release and Waiver

I, (hereinafter referred to as "Releaser"), hereby release, waive, discharge and covenant not to sue INFINITY OF CARE, INC., its owners, offices, directors shareholders, employees, agents, car owners and/or drivers (hereinafter referred to as "Releasees"), from any and all liability to the undersigned, his personal representatives, assigns, heirs, and next of kin for any and all loss, damage, or bodily injury (including death), and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned arising out of or related any automobile accident which occurs during the transport of Releaser by any Releasee to and/or from INFINITY OF CARE, INC. for medical treatment, whether caused by the negligence of the Releasees or otherwise. I hereby further agree to indemnify, defend and hold harmless the Releasees and each of them from any loss, liability, damage, or cost including bodily injury or property damage, they may incur arising out of my negligence or participation in any automobile accident which may arise during my transport to and/or from INFINITY OF CARE, INC. for medical treatment. I hereby farther assume fall responsibility for any risk of bodily injury, death or property damage arising out of or related to any automobile accident which may arise during my transport to and/or from INFINITY OF CARE, INC., whether caused by the negligence of Releasees or otherwise.

I hereby farther acknowledges that my transport to and/or from INFINITY OF CARE, INC. for medical treatment may be very dangerous and involve the risk of serious injury and/or death and/or property damage. I expressly acknowledge that injuries received may be compounded or increased by negligent rescue operations or procedures of the Releasees.

I hereby farther agree that this release and waiver of liability, assumption of risk and indemnity agreement extends to all acts of negligence by the Releasees, including negligent rescue operations in transporting me to and/or from INFINITY OF CARE, INC. for medical treatment, and is intended to be as broad and inclusive as is permitted by the laws of the Commonwealth of Pennsylvania in which medical treatment is conducted and that if any portion thereof is held invalid, it is agreed that the remainder shall continue in fall legal force and effect.

I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

Signature _____ Date_____

2 Park Lane Professional Building Suite 104 Feasterville, PA 19053-6004 web www.infinityofcare.com
Email service@infinityofcare.com Phone 215 953 9944 Fax 215 953 9943 Toll Free 866 953 9944

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ DOB:_____

Address:_____

Home Telephone Number: _____ Work Telephone Number: _____ Email Address: _____

Patient Identification Number and/or Social Security Number:_____

By signing this Authorization I authorize the person(s) and/or organization(s) described below to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1. of this form.

1. Description of Health Information I Authorize to be Used or Disclosed.

The following is a specific description of the health information I authorize to be used and/or disclosed (specific and meaningful description):

2. Persons/Organizations Authorized to Use and/or Disclose My Health Information.

I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations), to use and/or disclose the health information described above in Section 1. of this form.

3. Persons/Organizations Authorized to Receive and/or Disclose My Health Information.

I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information from the person(s) and/or organization(s) described in Section 2. Above. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

4. Right to Revoke.

I understand that I have the right to revoke this authorization at any time. I also understand that any revocation of this authorization must be in writing and directed to the persons/organizations identified in Section 2. and 3. of this form . I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Section 2. and 3. of this form have already made in reliance upon this authorization.

5. Expiration of Authorization.

This authorization will expire (choose and complete one):

On _____/_____/_____
month day year

Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information;

I,_____(please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____

Participant Signature **month day year**

If signed of personal representative, complete the following:

Name of personal representative _____

Relationship to participant or nature of authority (e.g., health care power of attorney, guardian other statutory authorization):_____

Address:

(Attach documents granting authority)

Home Telephone Number:

Work Telephone Number:

Email:

_____ _____/_____/_____

Signature of Personal Representative month day year

INFINITY OF CARE, Inc.
Philadelphia, PA
(215) 953 9944

Privacy Officer: Mikhail Slobodskoi Effective Date: April 1, 2003

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice
Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed accomplish the task will be shared.

Who We May Use and Disclose Medical Information About You
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services.
Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclosure medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to you insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution of law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare provider's treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' and healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosure of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filling a complaint.

Right To Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about you care. Usually this includes medical and billing records but does not include psychotherapy notes, information complied for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may by used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. It you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied you request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to Privacy Officer at this practice. In addition, you must provide a reason that supports you request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statement of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized request for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit you request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

Patient Signature _____