ASSIGNMENT OF BENEFITS

(For patients with primary Medicare coverage)

I,_____hereby assign all medical benefits to include major medical benefits to which I am entitled from Medicare and secondary insurances provided as crossover to Richard J. Pitch, MD or Long Island Neurocare Therapy.

This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for any charges whether or not paid by said insurance. 1 hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

Signature:_____Date: _____

PLEASE READ AND SIGN THE FOLLOWING

LETTER OF AGREEMENT

METHOD OF PAYMENT

You may pay by cash, personal check, credit card/debit card or money order. Any outstanding balances, co-payments and deductibles are due prior to being seen for your appointment.

If you wish to leave a credit card on file with our office to have your card automatically charged for services rendered in this facility, please fill in the information below. Note: Cards will only be charged as long as authority by the patient is granted. If you wish to revoke this agreement you may do so in writing at any time.

Type of Card: MasterCard O Visa O Discover O
Name on Card:_____Expiration Date: _____
Card #:_____Security Code:_____Zip Code: _____

Signature:_____Date:_____
Patient Name: _____
Witness:_____Date: _____

FINANCIAL POLICY

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire balance. Once the carrier is billed, we will set aside that portion of the balance estimated to be paid by your carrier for 90 days. We will do our best to contact carriers to establish why they have not paid or why they paid less than originally indicated if a claim comes back unpaid. If we are not paid by your carrier, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance we estimated, we will promptly refund the credit due amount to you. If you receive a check from the insurance company and you have agreed to assign benefits to our office, then you must endorse the check to the doctor treating you and your account will be credited. You authorize the doctor treating you to furnish any necessary information regarding your case to your insurance company and to

assign all benefits and amount not covered by your insurance company. **You agree to be billed $75 for cancelled appointments of less than 24 hours' notice as well as scheduled visits for which you do not show up. Confirmation calls two nights before your appointment serve as a courtesy reminder.**

In the event that your account is not paid in accordance with this agreement and turned over to our collections agency, you agree to pay all additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees.

CONFIDENTIALITY

Your treatment here is kept in the strictest of confidence. No one will be permitted any access to any information unless you specifically request, in writing, a release of information to a specific party at a particular time. Times when confidentiality must be breached are for your safety, the safety of others who may be in imminent danger, or when the records are subpoenaed by a Court of Law. In any situation that requires breach of confidentiality, attempts will be made to contact you beforehand. If you have any questions regarding this rule please ask as soon as you can so that any vague situations could be cleared up.

OUR AGREEMENT

It is possible that your treatment may involve more than one doctor housed within this practice. Your signature below gives consent for communication between doctors for the benefit of coordination of treatment.

Our contract reflects an active interest in your concerns. We are here to help you reach certain goals we agree on. Upon your signature at the bottom of this agreement, you indicate that you understand and agree to all the points of this contract.

Signature:_____Date: _____

Acknowledgement of Receipt of Privacy Practices

I,_____have received a copy of our Notice of Privacy Practices. (NEXT TWO PAGES)

Name of Patient: _____
(PLEASE PRINT NAME)

Address of Patient: _____

_____
(PLEASE PRINT ADDRESS)

Signature of Patient_____Date: _____

Name of Witness: _____
(PLEASE PRINT NAME)

Signature of Witness:_____Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, weather electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities asobtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH lNFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included by not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance requires by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the Present, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these

purposes would be necessary (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATJON,
- The right to request an amendment to your PROTECTED HEALTH INFORMATION,
- The right to receive an accounting of disclosures of PROTECTIVE HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice is upon request.

We are required by law to maintain the privacy of your PROTECTIVE HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)