Statement of Patient Financial Responsibility, Consent and Privacy Practice Policies

Work Star appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. I understand that if a: WORKCOMP claim is DENIED or CONTROVERTED, NO-FAULT claim is EXHAUSTED, or Your THIRD PARTY LIABILITY (TPL) DOES NOT include MEDICAL COVERAGE therefore, in order to continue care, in case of those circumstances or for any other reason, we require your PRIVATE INSURANCE be on file so that you do not be "Stuck with the Bill". Furthermore, without this essential information we may be unable to continue care.

Cancellation / No Show PolicyI understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. I understand if I no show for two appointments or cancel for a total of four appointments, I may be discharged from care or, if applicable, Work Star reserves the right charge a No-Show fee

Self-Pay

I understand if for any reason my health insurance has been terminated I will fully be responsible for services rendered here at WorkStar. I agree to pay Work Star, the full and entire amount of treatment given to me or to the above name patient at each visit.

Consent for Treatment and Authorization to Release Information

I hereby authorize Work Star, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedure. I further authorize Work Star, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Privacy Practice

It is the policy of our providers and staff to preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our providers and staff have the necessary medical and PHI to provide the highest quality of medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our providers and staff for the purposes of treatment, payment and healthcare operations (TO). To that end, our providers and staff will:

- Adhere to the standards set forth in this Notice of Privacy Practices
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our providers and staff will not disclose PHI for use outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our providers and staff will:
    - Implement reasonable measure to protect the integrity of all PHI maintained about patients
- Recognize that patients have a right to privacy. Our providers and staff respect the patient's individual dignity at all times. Our providers and staff will respect the patient's privacy to the extent consistent with providing the highest quality of medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our providers and staff will:
    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements.
    - Not disclose PHI data unless the patient (or his/her authorized representative) has properly authorized the release or law otherwise authorizes the release. Recognize that, although our providers "own" the medical record, the patient has the right to inspect and obtain a copy of his/her PHI. In addition, the patient has the right to request an amendment to his/her medical record if she/he believes his/her information is inaccurate or incomplete.
    - Permit patients access to their medical records when their written request are approved. If we deny their request, then we must inform the patient that they may request a review of our denial. In such case, we will have an on-site healthcare professional review the patient's appeal.
    - Provide patients with an opportunity to request the correct of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- Our providers and staff will maintain a list of certain disclosures of PHI for purposes other than TO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their request is in writing.
- Our providers and staff will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our providers.
- Our providers and staff must adhere to this policy. Our providers will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our provider's rules and regulations.
- Our providers may change this privacy policy in the future. Any changes will be effective upon the release of a revised policy and will be made available to patients upon request.

If patient is under 18, a signature is required by a patient of legal guardian. I understand and have read the above statement that was given to me.

Patient/Parent/Guarantor (Signature): _____

Patient/Parent/Guarantor (Print): _____ Date:_____