



Naperville Rehab Clinic
445 W Jackson Ave
Naperville, IL 60540

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Naperville Rehab Clinic has the right to accept or deny your request.

Naperville Rehab Clinic maintains a history of protected health information disclosures that are accessible to you.

In the future, we may contact you for appointment reminders, announcements, or to inform you about our practice and its staff.

Naperville Rehab Clinic is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our office at (630)961-1888.

The effective date of this Notice of Information Practices is April 14, 2003.

I acknowledge receipt of this notice _____
Patient's Signature Date



Naperville Rehab Clinic

Tony K Maghsoudi D.C.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

PATIENT Company Name _____ Occupation _____
Please list any and all insurance and/or employee healthcare plan coverage you or your spouse may have

INSURANCE INFORMATION Insurance Company or Health Care Plan Name _____
Policy/Group #: _____ Effective Date: _____
Name of Insured: _____ ID _____

SPOUSE COINSURANCE INFORMATION Please list any and all coinsurance and/or employee healthcare plan coverage you or your spouse may have
Insurance Company or Health Care Plan Name _____
Policy/Group #: _____ Effective Date: _____
Name of Insured: _____ ID #: _____

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? Yes No
Your Initials: _____

MEDICAL AND LEGAL INFORMATION If you answered yes, please fill out accident specific form, available at the front desk.
Pregnant Yes No Pacemaker Yes No
Family Physician _____
Person to contact in emergency (Name and Phone #) _____
Attorney _____ Telephone: _____
Address _____

PATIENT AGREEMENT

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **Naperville Rehabilitation and Pain Management Center P.C.** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bringing suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian # _____ Date _____