INJURY AND HEALTH INSTITUTE

Injury and Health Institute Privacy Notice

Patient Name: _____

Address:_____

DOB:_____

Email Address: _____

Workers Comp:___ Motor Vehicle Accident:___ Insurance: _____

Policy #:_____

Claim #:_____

Occupation:_____ Title:_____

Work Address: _____

Date of Injury: _____

What services are you here for today? Urgent Care:__ Physical Therapy:___ Pain Management:___ Orthopedics:___ Other:_____

Patient Privacy Notice

Here at Injury and Health Institute we strive to bring you the best quality of care. By signing this form, you acknowledge that we will have access to your Protected Health Information (PHI), and that we will need to receive and distribute your PHI to our providers.

Printed Name: _____

Signature:_____

How did you hear about us? Television__ Radio__ Referred__ Other: _____

HIPAA Compliance. To the extent applicable to this Agreement, IHI agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d ("HIPAA"), and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Part 142 (the "Federal Security Regulations"), the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, and all the amendments to HIPAA contained in Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), all collectively referred to as "HIPAA Requirements." Injury and Health Institute pursuant to this Agreement involves the use and/or disclosure of individually identifiable health information relating to Qualifying Patients ("Protected Health Information" or "PHI").