7617 Kennedy Blvd
North Bergen, NJ 07047
Office: (201)-854-1500
Fax: (201)-854-1505

Insurance Assignment & Release, Consent to Treat, Consent to use Disclose Protected Health Information (PHI), Receipt of Notice of Privacy Practices (HIPAA)

1.**Insurance Assignment and Release:**
I certify that I have insurance coverage with_____ and _____ and assign directly to De Lucia Advance Practice LLC all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurances. I authorize the use of my signature on all insurance submissions.

De Lucia Advance Practice LLC may use my health care information and may disclose such information to the above named insurance company (or companies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

2. **Patient Consent to Treat:** _____ **(Initials)**

I, the undersigned patient, consent to the administration of pain management treatments, and related procedures as deemed necessary by the Nurse Practitioners of De Lucia Advance Practice LLC, including those which are in addition to or different from those initially contemplated, when such procedures are deemed necessary or advisable by the provider in the course of the surgery or procedure.

3. **Patient Consent for Use and Disclosure of PHI:** _____ **(Initials)**

I, the undersigned patient, give my consent to De Lucia Advance Practice LLC to use or disclose my PHI to carry-out treatments, payments, or health care operations. These individuals and entities can release, use or disclose my PHI to other nurse practitioners, certified registered nurse anesthetists, anesthesia assistants, anesthesia staff, nursing staff, physician assistants, physicians, radiology personal and other such entities or persons as are deemed related to treatment, payment, and health care operations, as determined at the sole discretion of the provider, anesthesia group and their respective agents.

4. **Permission to Release Medical Records to Providers:** _____ **(Initials)**

If another provider who is involved with treatment, payment or health care operations relating to me requests my medical records, I consent to the release of my entire medical records maintained by the provider to those other providers.

5. **Permission to Release Billing Information Over the Telephone:** _____ (**Initials**)

I agree, as part of consent for payment operations, that the provider, its group and their billing personnel, billing agents or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number.

6. **Permission to Call and Leave Voice Mail Messages:** _____ **(Initials)**

I agree that the provider or its agents or representatives may call and leave a voice mail message at my home or other number I provide them regarding my medical appointments, billing or payment issues or other information related to treatment, payment, or health care operations.

7. **Permission to Discuss PHI with Third Party:** _____ **(Initials)**

I agree that the provider may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree that the provider may discuss my PHI with any person who identifies themselves as active in my mental, physical, emotional, or spiritual care. I also agree that the provider, her/his anesthesia group, and their agents may disclose my PHI to employers, who arrange and pay, directly or indirectly, for my medical treatment.

8. **Permission to Discuss PHI with Public Agencies:** _____ **(Initials)**

I agree the provider, her/his pain management group, and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.

9. **Acknowledgement of Receipt of Notice of Privacy Practices:** _____ **(Initials)**

I acknowledge that I have been provided from the provider a copy of a separate document, entitled, "Notice of Privacy Practices" which set forth this provider's privacy practices and my rights regarding privacy of my PHI.

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to De Lucia Advance Practice LLC, 7617 Kennedy Blvd, North Bergen, NJ 07047.

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Patient Name (Print)

Patient Signature **Date**