WORKERS' COMPENSATION

COMPREHENSIVE MEDICAL OFFICE,P.C
Jungman Michael Suh, MD
208-01 Northern Blvd. 4FL Bayside, NY 11361
T: 718-746-0900 F:718-746-2390

CHART# _____

PATIENT'S INFORMATION

Name: (Last)_____ (First)_____ (MI) _____

DOB: _____/_____/_____ S.S.#: _____

Address:_____(city)_____(state)_____(zip)_____

Phone #: Home (_____) _____ - _____ Cell (_____) _____ - _____

INSURANCE INFORMATION

DOA : _____/_____/_____

Carrier Case #: _____ WCB #: _____

Insurance Carrier Name:_____

Carrier Address :_____(city)_____(state)_____(zip)_____

Phone #: (_____) _____ - _____

Adjuster's Name: _____ Phone #: (_____) _____ - _____

EMPLOYER'S INFORMATION

Employer's Name:_____

Address: :_____(city)_____(state)_____(zip)_____

Phone #: (_____) _____ - _____

Attorney's Name: _____

Phone #: (_____) _____ - _____

Referring Provider's Name: _____

Phone #: (_____) _____ - _____

FINANCIAL AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby instruct and direct my insurance carrier to make all payments directly to: COMPREHENSIVE MEDICAL OFFICE,P.C for services rendered to me by said health care provider. This is a direct Assignment of my claim and rights for insurance benefits. I am responsible for any deductibles, if applicable. I understand that in the event my insurance carrier does not pay for any portion of the claim submitted for services provided to me, I will be personally responsible for any unpaid balance.

I authorize the release of any medical or other information necessary to process claims for services provided to me by the above named provider, practice, supplier or group. A photocopy of the Assignment shall be considered as effective and valid as the original.

Sign _____ Date: _____

PRINT NAME: _____ **SIGNED:** _____ **DATE:** ____/____/_____

HIPAA Notice of Privacy Practices

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.
Parts 160 and 164)

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

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to physical or mental health or condition and related health care services.

1. Authorization:

I, _____ authorize Dr. Jungman Michael Suh to use and disclose the protected health information described below.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain billing or claims payment for your health care services.

2. Effective Period
This authorization is for release of information all past, present and future periods.

3. Extent of Authorization

A. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

B. ☐ I authorize the release of my complete health record with the exception of the following information:
☐ Mental health records ☐ Alcohol/drug abuse treatment ☐ Other (please specify):_____

I authorize Dr. Jungman M Suh to release any or all information concerning my medical care to the following individual.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name: _____

Signature of Patient/Guardian: _____ Date: ___ /___ / _____