Central Park
Physical Medicine and
Rehabilitation, P.C.

Joyce Goldenberg, M.D.
Board Certified American Board of Physical Medicine and Rehabilitation

Account #: _____

Date: _____

Last Name _____ First Name _____

Address _____

SS# _____ Sex _____ Date of Birth _____

Phone (Res) _____ Phone (Cell) _____

Phone (Work) _____ Ext. _____ email _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Employment Information

Company: _____

Occupation: _____ Phone: _____

Address: _____

No-Fault

Company: _____

Adjuster: _____ email: _____

Phone: _____ Adj. Phone: _____

Policy #: _____ Claim #: _____

Address: _____

_____

Policy Holder: _____

D.O.A.: _____ Adj. Fax: _____

Workers Comp

Company: _____

Adjuster: _____ email: _____

Phone: _____ Adj. Phone: _____

Claim #: _____ WCB #: _____

Address: _____

_____

D.O.A: _____ Adj. Fax: _____

PRIVATE INSURANCE

Primary

Company: _____

Policy #: _____

Relation: _____

Address: _____

_____

Guarantor: _____

Phone: _____

Secondary

Company: _____

Policy #: _____

Relation: _____

Address: _____

_____

Guarantor: _____

Phone: _____

Attorney Information

Firm: _____ Attorney /Paralegal: _____

Telephone: _____ Fax: _____ email: _____

HIPPA Release

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name ,	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Central Park Physical Medicine/Joyce Goldenberg , MD 10 East 39 Street Floor 3, New York NY 10016

8. Name and address of person(s) or category of person to whom this information will be sent:
BARSHAY, RIZZO & LOPEZ, PLLC 445 Broadhollow Road | Suite CL18 Melville, New York 11747

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other:	End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Assignment of Benefits

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER (3/1/02)

I _____, _____ **(**"Assignor") hereby assign to
(Print patient's name)
CENTRAL PARK PHYSICAL MEDICINE & REHABILITATION, P.C. ("Assignee") all rights privileges and
(Health care provider name)
remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault Statute) of the Insurance Law.

The Assignee hereby certifies that they have not received payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _____, not withstanding any other agreement to the contrary
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLORS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____, _____
(Print name of Patient) (Signature of Patient)

_____
(Date of signature)

_____
(Address of Patient)

CENTRAL PARK PHYSICAL MEDICINE & REHABILITATION, P.C.
(Health care provider name)

DR. JOYCE GOLDENBERG, MD Goldenberg MD
(Print name of Provider) (Signature of Provider)

10 East 39th Street, 3rd Floor New York NY 10016 _____
(Address of Provider) (Date of signature)

NYS FORM NF-AOB (Rev 1/2004)

NF-2 Form

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. ☐ P.M. ☐	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: Mercy Hospital of Hartsdale

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ TBD	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☑ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

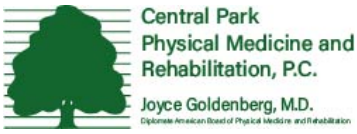
NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

Lien Assignment



LIEN ASSIGNMENT AGREEMENT

I, _____,_____residing at _____ _____, _____ hereby enter into the following agreement with **Central Park Physical Medicine and Rehabilitation P.C.**, hereinafter known as "the provider" in order to guarantee payment for services rendered by "the Provider" to me for an accident on _____. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier as applicable. This document further serves to acknowledge my responsibility to repay **all** remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien assignment and acknowledge responsibility for the repayment of all outstanding balances. I further direct that my attorney shall not subsequently dispute these amounts and, at my direction, will contact this office to arrange for full payment at the time a settlement, trial or motion proceed becomes ready for disbursement.

To the extent applicable, I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of No-Fault benefits. The patient herein further acknowledges their responsibility to file a timely notice of claim to the applicable insurance carrier and that any subsequent No Fault claim denied based on the failure to provide a timely notice, at the election of the provider, may result in recovery efforts in reliance of this lien.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided and to the extent the information is applicable. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of No-Fault benefits and result in the reliance on this lien for reimbursement purposes. I am aware that No-Fault coverage is premised on a viable policy that is not exhausted. If a policy exhausts prior to collection by Provider, I acknowledge that this Lien may be invoked as a primary payment method.

If patient provides insurance information for a No-Fault claim that indicates a third-party administrator and does not provide the name of the underlying insurer, Provider will submit the claim to the named entity but Patient agrees that

any assignment of benefits may be revoked retroactively by provider who will revert to this Lien for payment. Patient directs his attorney not to dispute any such revocation in favor of the lien where an entity, such as a third-party administrator cannot be pursued in Court for payment based on jurisdictional issues or where a policy exhausts prior to collection by Provider.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me or my ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby **direct** and **authorize** direct payment to "the provider", such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my case, I direct the substituted attorney to provide the incoming ATTORNEY with a copy of this lien and that I direct any incoming ATTORNEY to honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct and authorize my attorney, on demand, to provide the status of such litigation to "the provider" or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact "the provider" or the attorney representing the provider prior to disbursement of any funds to ascertain any outstanding.

_____ Date	_____ Patient's Attorney's Signature
_____,_____ Patient's Name	_____ Patient's Attorney's Stamp
_____ Patient Signature	_____ Attorney Address/Phone

Uploaded October 3, 2021

Central Park Physical Medicine and Rehabilitation
Financial Policy (No Fault)

Thank you for choosing Central Park Physical Medicine & Rehabilitation [CPPM&R } as your health care provider. We are committed to your treatment being successful. Our Financial Policy requires you to read and sign this financial agreement prior to any treatment. Please understand that payment of your bill is in not only required but is considered a part of your treatment.

All patients must complete our Information and Insurance form before seeing the doctor. Please be advised that P.O. Boxes are not accepted and a valid street address is required for each patient.

Upon processing your No Fault application your insurance carrier will assign you a case number. In the interim, CPPM&R will normally accept a signed Assignment of Benefits and Lien (both in this packet) as a promissory payment.

THE FOLLOWING CONDITIONS WILL CAUSE YOU TO BE PERSONALLY RESPONSIBLE FOR YOUR BILL:

1. A No-Fault application of benefits must be filed with the insurance company within 30 days of the accident. Failure to submit the application timely will result in your entire case being denied. It is your responsibility to confirm that the carrier has the application of benefits before the 30-day threshold expires.
2. All cancellations with out a 24 hour prior notice will be considered a "No-Shows" and will be billed at $50 per session. *Note: Excessive cancellation or "No-Shows" of physical therapy sessions will cause CPPM&R to cancel future appointments.*
2. Any insurance checks for treatments issued and received by you from the insurance company which are not turned over to (CPPM&R).
3. Failure to attend any Independent Medical Examinations (IME) or Examination Under Oath (EUO) that are required by the insurance carrier. CPPM&R expects prompt notification as soon as you are scheduled for an IME or EUO.
4. Note: The law states that if you were the driver involved in a motor vehicle accident and deemed as Driving While Under the Influence (DWI), your insurance carrier will not pay for treatment.

Thank you for your anticipated cooperation.

I authorize payment of medical benefits directly to Central Park Physical Medicine and Rehabilitation.

Patient's Name _____, _____

Patient's Signature _____

Date _____

Notice of Privacy Practice
NOPP

Central Park Physical Medicine and Rehabilitation
ATTACHMENT D

Effective Date: April 14, 2003

ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility, and how I may obtain access to and control this information:

_____
Signature of Patient or Personal Representative

_____, _____
Print Name of Patient or Personal Representative

_____
Date

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

The patient refused to sign despite good faith efforts
The patient was unaccompanied and not alert and oriented
The patient was unaccompanied and needed emergency care
Other, (explain): _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ Date: _____

Acknowledgement subsequently obtained, (see above).

Central Park Physical Medicine and Rehabilitation, P.C.
Joyce Goldenberg, M.D.

SUMMARY-NOTICE OF PRIVACY PRACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMA-TION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Our Pledge to Protect your Privacy:

Central Park Physical Medicine & Rehabilitation, P.C. is committed to protecting the privacy of your medical information. So that we can best meet your needs, we share your medical information with all the healthcare providers involved in your care. Only to the extent necessary, we also use and share your information to conduct our business operation, to collect payment for the services we provide to you and to comply with the laws that govern healthcare. We will not use or disclose your information for any other purpose without your permission.

Examples of how we may use and disclose your health information:

- To bill and receive payment for the treatment and services you receive;
- For functions necessary to run Central Park Physical Medicine & Rehabilitation, P.C and to assure that our patients receive quality care;
- To provide only demographic information to our development office for purposes of Marketing.
- To support our research mission as an academic medical center with approval of our Institutional Review Board (IRB);
- For workers' compensation or similar programs;
- For required public health activities (e.g., reporting abuse or adverse reactions to medications);
- For healthcare oversight (e.g., to the New York State Department of Health);
- For law enforcement in certain limited circumstances;
- To a coroner, medical examiner or funeral director as required by law;
- For organ procurement or transplantation, if you are a potential donor.

NOTICE OF PRIVACY PRACTICES

We Must use and disclose your health information to provide information;

- To you or someone who has the legal right to act for your (your personal representative)
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information;

- For Payment and to process claims for health care services you receive.
- For treatment. We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- For Health Care Operations. We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your pharmacist or your doctor to suggest a disease management or wellness program that could help improve your health,
- To provide Information an Health Related Programs or Products such as alternative medical treatments and programs or about health related product and services.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with our providers who provide medical care to you.
- **Business Associates**. We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an insurance company or law firm, or a risk management organization in order to obtain professional advice about how to manage risk and legal liability, including insurance or legal claims. We may also share your health information with an accounting firm in order to obtain advice on legal compliance. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

We may use or disclose your health information for the following purposes under limited circumstance;

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.

- **For Pubic Health Activities s**uch as reporting disease outbrew.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To A void a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws ofjob*related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, it the research study meets all privacy law requirements
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

If none of the above reasons applies, then we must get your written authorization to use or disclose your health information. If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the re-quirements of the more stringent law. In some states, your authorization may also by require for disclosure of your health informa-tion. In New York State, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact our Medical Records department at (212) 447-0300.

WHAT ARE YOUR RIGHTS

• **You Have The Right To See and Obtain** a copy of your medical and billing records, subject to some special requirements for substance and alcohol abuse, genetic, mental health and HIV-related data. You may also receive a summary of this health information. You must make a, written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information. We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days if the information is located in our facility and within 60 days ifit is located off-site at another facility. If we need II additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can .expect to have a final answer to your request. If you request a copy of the information, we may charge a fee, as permited by law, for the costs of copying, mailing or other supplies we use to fulfill your request. The fee must generally be paid before or at the time we give the copies to you.

• **You Have The Right To Ask To Restrict** certain uses or disclosures of your medical information; Please note that while we will be to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.

• **You Have The Right To Receive An Accounting** of disclosures of your medical information made by us during the six years prior to your request. This accounting will not include disclosures of information; (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials;and (v) other disclosures that federal law does not require us to provide an accounting.

• **To add an addendum** to your medical record. Information we maintain about you may be amended if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information. You Have The Right To Ask To Receive Confidential Communications of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address)

• **You Have The Right To Receive A Copy Of This Notice**. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. A copy of our current notice will always bi posted in our reception area. You will also be able to obtain your own copies by accessing our website at www. stoppingpain.com, or calling our office and asking for one at the time of your next visit: ***36th Street Location: (212) 447-0300, 86th Street Location: (212) 787-7994.***

- **Contacting Us.** If you have any questions about this notice or want to exercise any of your rights, please call {212) 44 7-0300.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address

EXERCISING YOUR RIGHTS

Central Park Physical Medicine & Rehabilitation, P.C., 200 Madison Avenue,@36th St., New York, NY 10016

Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Hypertension

Central Park Physical Medicine and Rehabilitation
HYPERTENSION DISCLAIMER ATTESTATION

Hypertension or elevated blood pressure is a dangerous and insidious condition that can lead to stroke, heart attack, heart failure and kidney failure. It is a silent killer. Therefore, I understand that it is my responsibility to have this condition treated by my primary care doctor or hospital emergency department. My failure to have this condition treated and the consequences thereof are solely my responsibility and do not hold liable the doctors and therapists treating me for my accident.

Patient's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____

ACKNOWLEDGMENT OF OBTAINING PRIMARY CARE FOR MEDICAL CONDITIONS NOT RELATED TO MY NO-FAULT ACCIDENT

I am aware of my responsibility to seek medical treatment from my primary care physician for all conditions not related to the injuries sustained in my accident. If I fail to properly seek medical care and follow medical advice for afflictions or conditions not related to my accident, I am solely responsible.

Patient's Signature: _____ Date: _____

Witness's signature: _____ Date: _____