106 Elden St, Suite 18B

Herndon, VA 20170

P:703-723-9100, F: 7037239200

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Northstar Health for any services provided to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance company. I also authorize you (Northstar Health) to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Signed: _____Date: _____

MEDICARE Lifetime Signature on File:

I request that payment of authorized Medicare benefits be paid on my behalf to Northstar Health for any services provided to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its intermediates any information needed to determine these benefits or benefits payable for related services.

Signed: _____Date: _____

Consent for Treatment.

I consent for Northstar health to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives.

Patient Initials: _____

Electronic Prescription. I understand Northstar Health utilizes electronic prescribing technology and participates with Surescripts that operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists.

SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Patient Initials: _____

Missed or Cancelled Appointments

1. If you are unable to keep an appointment, we ask that you kindly provide us with at least 24-hour notice. Failure to provide a notice will result in a NO show or Fail to Cancel Fee of $35.

Your Co-pay

As per your insurance contract, your Co-pay is due at the time of Service and must be paid, without exception. You are responsible for all charges incurred during your visit including any amounts not paid by the insurance.

Your Insurance Deductible

Please understand that you will be responsible for full payment of your bill if you have a deductible on your insurance plan or if you do not notify us at the time of your visit of your current insurance information. In the event you default on your account balance, the account will be forwarded to a collection agency.

Notice of Narcotic Policy

I understand that Northstar Health does not prescribe narcotic medications for long term use or chronic pain.

I understand I will be referred to a specialist or pain management clinic. I fully accept and will comply with this policy.

Patient's Full Name: _____

Patient's Signature: _____ Date: _____/_____/_____

HIPAA Notice of Privacy Practices

Northstar Health is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you would like to obtain a full copy of the HIPAA Notice of Privacy for your records or if you have any objections to this form, please ask Northstar Health in person or by phone 703-723-9100 or email: medical@northstar-health.com

Signature below is only an acknowledgement that you have reviewed this notice of privacy practices posted at the reception's desk/Waiting Area at NorthStar health.

Family members or others you authorize us to discuss your protected health information with:

Person's Last Name: _____ First Name: _____
Phone Number: _____ Relationship: _____
Person's Last Name: _____ First Name: _____
Phone Number: _____ Relationship: _____

Expiration Date of Authorization

This authorization is effective unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization.

You may revoke or terminate this authorization by submitting a written revocation to Northstar Health or You should contact the office manager to terminate this authorization.

I verify that the information I have provided above is accurate.

Last Name: _____ First Name: _____
Patient's Signature: _____ Date: _____/_____/_____