CENTER FOR HEALING NEUROLOGY

2018 Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

By my signature below I, _____,
[print your name above]
acknowledge that I **received** a copy of the Notice of Privacy Practices for Center for Healing Neurology.

_____ _____
Signature of patient (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

Patient's Name: _____

Personal Representative's Name: _____

Relationship to Patient: _____

I hereby designate the following individual(s) to receive communications from the Center for Healing Neurology that may include health information about me/patient:

1. _____ 2. _____

I authorize Center for Healing Neurology to leave voice mail messages concerning my health information (i.e., lab results, appointment instructions, etc.) at the following number(s):

Phone (____) ____-____ (patient initials) _____ ❒ Home ❒ Cell ❒ Work

Phone (____) ____-____ (patient initials) _____ ❒ Home ❒ Cell ❒ Work

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❒ Individual refused to sign
❒ Communications barriers prohibited obtaining the acknowledgement
❒ An emergency situation prevented us from obtaining acknowledgement
❒ Other (Please Specify) _____

Employee Name:_____ Date _____

CENTER FOR HEALING NEUROLOGY

Financial Policy and Consent Form

Integrative Child and Adult Neurology, PLLC (DBA: Center for Healing Neurology) financial policy and consent form.

1. Payment is requested at the time of service; this includes but is not limited to co-payments, deductibles, and non-covered services. We accept checks, Master Card, Visa, American Express and Discover Card.
2. We request 48-hour advance notice for appointment cancellations so that we have time to fill cancelled appointments from our wait list. Cancellations made less than 24-hours prior to the scheduled appointment will be billed a $100 "no-show" fee. The $100 fee is due prior to scheduling future appointments. This fee also applies to patients who make an appointment and neither use nor cancel it.
3. As a courtesy, we will bill your PRIMARY insurance for you and send any necessary reports to assist with reimbursement. We will bill your SECONDARY insurance for you as a courtesy.
4. All Balances are due within 60 days of initial billing. SPECIAL NEEDS: Special needs are understood by this office. It may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation is necessary for you, please bring this to our attention as soon as possible.
5. Legal agreements between parents accepting or denying financial responsibility for medical bills are not recognized by this office.
6. TO OUR MEDICARE PATIENTS: We are Medicare providers. Because of all the new laws and changes in allowed and non-covered services, we will bill Medicare for services rendered, however it is office policy to have all Medicare patients sign a waiver at each office visit that holds the patient responsible for any services that are non-covered.
7. A finance charge of 1% per month, up to 12% per year is applied on all accounts 60 days past due.
8. We will make every effort to expedite accurate claims to your insurance company for prompt reimbursement, but the agreement of the insurance company to pay for your medical care is a contract between you and the insurance company. The bill remains your responsibility.
9. USE/DISCLOSURE OF PERSONAL HEALTH INFORMATION AND ASSIGNMENT: By signing on the line below this paragraph, you give consent for the doctor, Center for Healing Neurology and the insurance company to use and/or disclose any personal health information required to process your medical claims, perform any required medical treatment or perform required administrative operations. You may refuse to give consent to use and/or disclose your personal health information for treatment, payment and operations, but in so doing, Center for Healing Neurology may refuse to provide you with treatment services. You have the right to revoke your consent in writing to the extent that the doctor, Center for Healing Neurology and the insurance company have taken action in reliance on your original consent. Furthermore, by signing on the line below you authorize your insurance benefits to be paid directly to Center for Healing Neurology.

Please sign in the space provided to indicate that you understand the financial policy, use and disclosure of information, and assignment:

Signed:_____ Date:_____

CENTER FOR HEALING NEUROLOGY

Medical Emergency Protocol

If you are experiencing a medical emergency or other urgent health condition, call emergency services (911) immediately. Do not rely on messages, voicemail, communications through the clinic's website, or any other electronic communications for immediate, urgent medical needs. Such communications are not designed or intended to facilitate patient care in urgent or emergency situations. Voicemail and other forms of electronic communications are not continuously monitored, and the providers of Integrative Child and Adult Neurology, PLLC (DBA: Center for Healing Neurology) make no guarantee of any particular response time.

_____ _____

Patient Signature (or personal representative) Date

_____

Patient Name