THE NEUROLOGY GROUP
EEG/EPSTUDIES•EMG/NCV•VASCULAR STUDIES

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Acknowledgement of Receipt of Notice of Privacy Practices
PATIENT INFORMATION CONSENT FORM

I have read and fully understand The Neurology Group Notice of Information Practices. I understand that The Neurology Group may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to my treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that The Neurology Group will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Neurology Group Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____
Patient Name Date

_____ _____ _____ _____
Patient or Guardian Signature Date updated Patient or Guardian Signature Date update

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship:_____ Name: _____ Relationship: _____

Name: _____ Relationship:_____ Name:_____ Relationship: _____

_____
Patient or guardian signature

INSURANCE/PAYMENT AUTHORIZATION FORM

I understand that charges for medical services in this office are my responsibility. Appropriate efforts will be made by this office to bill my insurance, workman's comp, etc. if applicable, however I understand that co-pays, deductibles, and ultimately the total amount of my bill is my responsibility and I will be expected to settle my account in a timely manner. I authorize the release of medical information to process claims. I authorize payments under my insurance programs to be made directly to The Neurology Group for any services furnished to me. I also designate that any settlement from litigation first be applied to my medical bills from this office. This authorization also permits the release of information by HCFA (its intermediates or carriers) on any UNASSIGNED Medicare claims to the above. I further permit copies of this authorization to be used in place of the original.

_____ ***Date:*** _____

Patient (or responsible party) signature