Consent to Treatment

I give my consent to the practitioners of Adult Neurology Center, P.C. to perform medical services determined to be necessary or advisable for the benefit of my healthcare.

Adult Neurology Center is authorized to use and disclose my protected health information for treatment, payment, and operations consistent with its Notice of Privacy Practices.

_____
Patient Initials

Medicare Certification and Other Insurance Assignment of Benefits

I authorize and assign direct payment to Adult Neurology Center, P.C. for all charges incurred for services rendered. I also authorize Adult Neurology Center, P.C. to furnish all medical information to carriers concerning my illness and treatment for the purpose of payment for services rendered. If applicable, I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of any protected health information about me to release to the Centers for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf and approve submission of a claim to Medicare or other insurance as applicable.

I am aware that it is my responsibility for all fees regardless of insurance coverage. If my insurance should deny payment for any services rendered, I understand that any outstanding balances owed to Adult Neurology Center. P.C. will be my responsibility to satisfy**.**

_____
Patient Initials

Electronic Prescribing

I give permission for the staff and Practitioners of Adult Neurology Center, P.C. to submit my prescriptions electronically to my Pharmacy.

_____
Patient Initials

Preferred Method of Communication for Appointments

Select one: ☐ Home Phone ☐ Cell Phone ☐ Other Phone Number _____

Adult Neurology Center employees may leave appointment reminders and test results on my answering machine/voice mail. ☐ YES ☐ NO

Consent to Disclosure of Personal Health Information to Family Member(s)/Identified Person(s)

I give my consent to the practitioners and staff of Adult Neurology Center, P.C. to release information regarding my medical care, including my medical condition, test results, appointment dates/times *to the following individuals*:

Name	Relationship	Telephone Number

☐ **Check this box if you do not wish to list anyone below.**

_____ _____ _____
Name of Patient (Printed) SIGNATURE of Patient (or personal representative) Date of Birth

_____ _____ _____
Name of Personal Representative (if applicable) Relationship Today's Date