CHILD NEUROLOGY SERVICES P.C.
CONSENT FOR SERVICES AND OFFICE POLICIES

Patient Name: _____ Date of Birth: ____/____/____

AUTHORIZATION FOR TREATMENT:
I authorize Child Neurology Services PC to provide treatment to myself or the above named patient. I will provide an insurance card and a picture ID at each visit. I authorize Child Neurology Services PC to leave appointment reminders on my answering machine or with a family member; mail reminders to make an appointment on postcards to my home address; mail normal lab and/or test results to my home address in a sealed envelope; leave general questions/medical information on my answering machine or with a family member.

NOTICE OF PRIVACY PRACTICES:
I agree and understand the Provider's use of Protected Health Information as described in the notice for treatment, payment, and/or health care operations. I understand that I must provide a separate authorization before any disclosures may be made, except as otherwise specified. If for any reason my PHI is breached, I will be notified as required by law. I understand that a copy of these regulations is available at the reception area.

ASSIGNMENT OF BENEFITS:
I hereby assign to Child Neurology Services PC all payments from my insurance company for medical services rendered to me or my dependents.

PAYMENT AGREEMENT/COLLECTION POLICY:
I understand that payment is due at the time of service. Even though insurance may be filed, I understand that bills are payable upon receipt and that I, not the insurance company, am ultimately responsible for payment of all services, regardless of any divorce decree, pending litigation, or court order stating otherwise. Patients not presenting evidence of insurance will be considered self-pay and may be asked to pay in full at the time of service. I understand that this office accepts many insurance plans and that it is my responsibility to verify that the provider my child is seeing is on my specific plan. If my insurance company requires a referral, it is my responsibility to verify with my child's Primary Care Doctor that a referral has been issued. If a referral has not been issued at the time of service, I understand that I will be asked to reschedule or will be asked to sign a financial responsibility agreement. I understand that if my account gets sent to an outside collection agency, I will be responsible for the balance due, plus any costs that are incurred by Child Neurology Services PC in collecting my debt. If I write a check to Child Neurology Services PC and it is returned, I understand there will be a $20.00 charge added to my account. I understand that if a provider from Child Neurology Services PC treats my child in the hospital, there will be a separate bill for these services.

APPOINTMENTS:
I understand appointment reminders are a courtesy and every effort will be made to provide me with this service. I understand that I must give a 24 hour notice to cancel or reschedule my appointment. If an appointment is missed without notification, I understand there will be a $25.00 fee charged to the guarantor. I understand two or more appointments missed may result in termination of care for my child. I understand that any patient not seen within the past 3 or more years is considered a new patient and will be charged accordingly.

PRESCRIPTIONS:
I understand prescriptions will be filled during normal business hours (please allow up to 48 hours). I authorize Child Neurology Services PC to access my electronic records of previously prescribed medications through an external electronic prescribing network. I authorize Child Neurology Services PC to request a Prior Authorization and/or issue an appeal for all prescriptions requiring such.

USE OF PROTECTED HEALTH INFORMATION:
I authorize release of copies of pertinent medical records to providers outside of Child Neurology Services PC who are being consulted with and/or I am being referred to in connection with my current treatment and to insurance companies for the purpose of determining benefits and/or coordination of care. I understand that I may submit a written request for a copy of my child's medical records. I understand that it may take 10-14 business days to receive these records and that there will be a charge. I understand that this office does not release records provided by another practitioner or facility. If I need copies of these records, I must obtain them separately.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

____/____/____ _____ _____
Date Signature Parent/Legal Guardian/Patient (if over 18) Relationship to Patient