



Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

1. By my signature below I, _____, [print name of signer – patient, parent or personal representative]

acknowledge that I have reviewed, or was given the opportunity to review, a copy of the Notice of Privacy Practices for Center for Healing Neurology.

Signature of patient, parent or personal representative Date

2. *If this acknowledgment is signed by a parent or personal representative on behalf of the patient, complete the following:

Patient's Name: _____

Personal Representative's Name: _____

Relationship to Patient: _____

3. 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. _____

4. I authorize Center for Healing Neurology to leave voice mail messages concerning my health information (i.e., lab results, appt. 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 _____



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, if we are contracted with your insurance carrier, 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 no longer contracted with Medicare as of April 1, 2018. We therefore are unable to submit medical claims to Medicare.
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: _____

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