CENTER FOR HEALING NEUROLOGY

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

*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: _____

2. 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. _____

3. 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 _____

CENTER FOR HEALING NEUROLOGY

Patient Name:_____

DOB: _____

APPOINTMENT REMINDER AUTHORIZATION FORM

Please choose one or more of the following appointment reminder options

EMAIL APPOINTMENT REMINDER

I, _____, authorize Center for Healing Neurology to send APPOINTMENT REMINDERS electronically via EMAIL to the following email address.

EMAIL ADDRESS (please print clearly): _____

TEXT MESSAGE APPOINTMENT REMINDER (available beginning July 2019)

I, _____, authorize Center for Healing Neurology to send APPOINTMENT REMINDERS electronically via TEXT MESSAGE to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number:

MOBILE #: _____

VOICE MESSAGE APPOINTMENT REMINDER

I, _____, authorize Center for Healing Neurology to contact me for APPOINTMENT REMINDERS via VOICE MESSAGING. If I am unable to answer the telephone, I give Center for Healing Neurology permission to leave a message on my voicemail or with the person answering the telephone

TELEPHONE #: _____ ☐mobile ☐home ☐work

_____ ☐mobile ☐home ☐work

Patient Signature: _____ **Date:** _____
OR
Parent/Legal Guardian Signature: _____ **Date:** _____

CENTER FOR HEALING NEUROLOGY

Financial Policy and Consent Form

Integrative Child and Adult Neurology, PLLC (DBA: Center for Healing Neurology)

1. Payment is requested at the time of service. We accept checks, Master Card, Visa, American Express and Discover Card. Some services require a 50% deposit at time of scheduling and final payment one week prior to appointment.
2. INSURANCE: As of July 1, 2019, Center for Healing Neurology will no longer bill insurance for patient appointments, with the following exceptions: For Dr. Issa only, we will bill Premera, Lifewise and Anthem Insurance Plans. For Gillian Ehrlich, DNP, ARNP only, we will bill Medicare.
3. SUPERBILLS: Superbills will be provided upon patient request. Superbills are receipts that can be submitted by the patient to their insurance carrier for possible reimbursement. The agreement of the insurance company to pay for your medical care is a contract between you and the insurance company. Please allow up to a week for superbill processing.
4. APPOINTMENT CANCELLATIONS: We request cancellations at least 5 business days in advance for initial consultations and 2 business days in advance for all other appointment types. This allows us to fill cancelled appointments from our wait list. Late cancellations and no-shows will be billed a $100 "no-show" fee [Please note: For patients who made a $250 deposit for an initial consultation with Dr. Ruhoy, the deposit will be forfeited in lieu of incurring a no-show fee. To receive a refund on the initial consultation deposit (less a 5% processing fee), the appointment cancellation must be received at least 5 business days in advance of the appointment.]
5. **PATIENT BALANCES: All outstanding balances are due at time of appointment or within 60 days of initial billing, whatever comes first.**
6. Legal agreements between parents accepting or denying financial responsibility for medical bills are not recognized by this office.
7. 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