York Neurology, Headache, and Facial pain Center

1Brickyard Lane, Suite EE

York, Maine 03909

Patient Consent Form:

## Consent for Treatment

I, the undersigned, hereby consent to the treatment and procedures provided by the Neurology Office, including but not limited to diagnostic tests, medications, and therapeutic procedures.

 I Have the right to accept or refuse any medical or surgical care, treatment or procedure.

 I understand that I have the right to be informed about risks, benefits and the alternatives to any care, treatment or procedure before I receive it.

The consent to the authorized release of prescription eligibility and prescription history that may be obtained via EMR.

I authorize the release of information needed to continue my care or determine benefits for services rendered.

I request that all payment of authorized benefits be made directly to Mainely Migraine LLC.

I acknowledge that I am financially responsible for any copay, coinsurance, deductible, denial or any outstanding balance relating to my health care.

 I am responsible for providing Mainely Migraine LLC, (York neurology, Headache, and Facial Pain Center), with the most current insurance information.

I further understand that if I do not provide my current insurance, I will be responsible for payment of service.

 In the absence of appropriate referrals or pre authorization, I agree to accept full responsibility for any charges related to the service performed by Mainely Migraine LLC.

 I acknowledge that there will be a $25 service fee for any return checks.

I acknowledge Mainely Migraine LLC is able to charge a $75 fee for missed appointments.

I am aware the Mainely Migraine LLC privacy notice, explaining your information, your rights, and our responsibilities has been offered to you and it will explain further about how information may be used and disclosed.

I consent to the use of photography (and the right to refuse the use of photography) for clinical/teaching purposes and acknowledge that they will remain part of my record.

 I've had the opportunity to receive and review the privacy notice and may request an updated copy at any time.

I understand that the practice of medicine is not an exact science and that no guarantees or promises have been made to me regarding the outcome of my care.

## Release of Medical Information

I authorize the Neurology Office to release my medical information to my insurance company, the referring physician, and other healthcare professionals involved in my care. I understand that my medical information will be kept confidential and will only be shared when necessary for my treatment or as required by law.

## Financial Responsibility

I understand that I am responsible for the payment of all medical services provided to me by the Neurology Office. I agree to pay any copayments, deductibles, and other charges not covered by my insurance. I also understand that if my insurance does not cover the services provided, I will be responsible for the full payment.

## Patient Rights and Responsibilities

I acknowledge that I have received a copy of the Patient Rights and Responsibilities document provided by the Neurology Office. I understand my rights as a patient and agree to fulfill my responsibilities as outlined in the document.

## Signature

By signing below, I acknowledge that I have read and understood the information provided in this consent form. I consent to the treatment and services provided by the Neurology Office and agree to the terms outlined above.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_