QUALITY NEUROLOGY

6800 NW 9th Blvd Ste 2
Gainesville, FL 32605

2970 W US Hwy 90 Ste 110
Lake City FL, 32055

Phone: 352-478-4700
Fax: 352-225-3399

Acknowledgement and Authorization

Name: _____ **DOB:** _____

- I have read and understand the HIPAA/Privacy Policy for Quality Neurology LLC.

- I acknowledge that Quality Neurology LLC participates in a two-way record sharing portal with other providers/pharmacies that will enable records/medications to be sent and viewed if you are a mutual patient, unless otherwise stated by patient not to portal share records.

- I hereby assign my insurance benefits to be paid directly to the Healthcare Provider.

- I authorize Quality Neurology LLC to release medical information required to process my claim.

- I have read and understand the Financial Policy for Quality Neurology LLC.

- I authorize Quality Neurology LLC to obtain access to my medication history.

- I give my consent for care and treatment provided by Quality Neurology LLC.

By signing below, you acknowledge that you have read and understand the policies listed above.

Patient Signature

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Medical Disclosure Form

Name: _____ **DOB:** _____

I hereby authorize the disclosure of my Quality Neurology medical information to the following individuals:

Name/Relationship:

_____

Name/Relationship:

_____

Name/Relationship:

_____

Emergency Contact *Please list name and phone number*

_____

Do you have an Advance Directive? ___ Yes ___ No

If yes, please provide name and contact information of designated individual.

_____

_____

_____

Patient Signature

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24 Hour Cancellation Policy

Due to an increase in short term cancellations and missed appointments, we are now charging a fee for all missed appointments. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Quality Neurology reserves the right to charge a **$50.00 fee** for all missed appointments ("no shows") and appointments that are cancelled without a compelling reason, without a 24-hour advanced notice. All EEG and EMG appointments will be charged a **$100.00 fee** if not cancelled within a 24-hour advanced notice.

Missed appointments ("No Shows") and Cancelled appointments with less than a 24-hour notice, will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next scheduled appointment. Two missed appointments, or two appointments cancelled with less than a 24-hour notice will result in termination from our practice.

If you are more than 10 minutes late for an appointment, your appointment will be rescheduled, and a missed appointment will be recorded in your record.

Thank you for your understanding and cooperation, as we strive to best serve the needs of all patients.

We accept cash and all major credit cards as payment.

By signing this policy, you acknowledge that you have received and understand this policy.

_____	_____	_____
Print Patient Name	Patient Signature	Date

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Authorization to Release Medical Information

I hereby Request and Authorize:

Lucas Beerepoot, MD; David Brandon Burtis, DO; Lindsay Falk, APRN; Dominique Greene, APRN of Quality Neurology

To Obtain From: _____

_____

The Following Information: ☐ All PHI IN Medical Records

☐ Other: _____

From the Medical Records of:

Patient Name: _____

Date of Birth: _____

Last 4 Digits of Social Security Number:

_____

For the Purpose of: Continuation of Care

All INFORMATION HEREBY AUTHORIZED, MAY BE OBTAINED FROM THIS AGENCY AND WILL BE HELD STRICTLY CONFIDENTIAL AND CANNOT BE RELEASED BY RECIPIENT WITHOUT MY WRITTEN CONSENT. I UNDERSTAND THAT THIS AUTHORIZATION MAY INCLUDE SENSITIVE INFORMATION, SUCH AS COMMUNICABLE DISEASES/INFECTIONS, ALCOHOL OR DRUG USAGE/ABUSE, AND PSYCHOLOGICAL ISSUES.

Patient Signature/Date