MR #: ____________________

Date: ____________________

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

MR #: _______________

Medical Disclosure Form

Date: _________________

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

Exposure notification

Letter to patients about COVID-19 exposure while visiting health care facilities

Dear patient,

Exposure to other people, even those who do not have any symptoms, including health care providers, includes the risk of exposure to the COVID-19 virus. The virus is thought to spread mainly from person-to-person, mostly between people who are in close contact with one another (within about 6 feet), through respiratory droplets produced when an infected person coughs or sneezes. The virus may also be transmitted when touching a contaminated surface and then touching your face.

Visiting health care facilities, like any other location where many people gather or visit, does create a greater risk of exposure to COVID-19 virus. Quality Neurology, LLC follows the Florida Department of Health guidelines to reduce the risk of transmission of COVID-19 virus in hospitals and clinics.

Please be aware of symptoms including fever, sore throat, coughing, difficulty breathing, headaches and muscle aches. Please contact your primary care doctor if you have any of these symptoms and let your provider know that you have visited a health care facility.

By signing this letter you acknowledge that Quality Neurology, LLC provides the option of Telehealth in lieu of in-office appointments, and cannot be held liable for possible exposure during your visit.

____________________________________ ____________________

Patient Signature Date

QUALITY
NEUROLOGY

MR #: ____________________

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Quality Neurology LLC, its affiliates and its employees. Quality Neurology LLC will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Quality Neurology LLC. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA").

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc. Quality Neurology participates in a two-way record sharing portal with other providers that will enable records to be sent and viewed if you are a current patient with them, unless otherwise stated by patient not to portal share records.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment. Quality Neurology may also share information with collection agencies, if we are unable to receive payment owed to us.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence.

We will only make this disclosure if you agree or when required or authorized by law;

- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable format, if readily producible. Records will not be emailed to personal email addresses but will be available for pick up in the office or mailed to recipient. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice.

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Quality Neurology LLC Privacy Officer by phone at (352) 478-4700 or at the following address: 6800 NW 9th Blvd Suite 2 Gainesville, Fl. 32605. This Notice of Privacy Practices is also available on our Quality Neurology LLC web page at www.qualityneurology.com

______________________________ ______________________________ ______________________________

Please Print Patient Name Patient Signature Date

QUALITY
NEUROLOGY

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

6800 NW 9th Blvd. Suite 2 Gainesville, Fl. 32605

2970 W US Hwy 90 Suite 110 Lake City, Fl. 32055

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

MR#: ______________

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