QUALITY NEUROLOGY

6800 NW 9th Blvd Ste 2
Gainesville, FL 32605

1717 SW Newland Way
Lake City FL, 32025

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

Authorization to Release Medical Information

I hereby Request and Authorize:

Lucas Beerepoot, MD, and Lindsay Falk, APRN of Quality Neurology

To Obtain From: _____

_____

To Release To: _____

_____

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

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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.

Please select the appropriate consent option to authorize the exchange of patient health information through networks connected via the Interoperability Hub.

Please note: Opting out may limit our ability to access important information about your health condition, which could impact the coordination of your care and potentially affect health outcomes.

☐ Opted in: Send and Receive Documents ☐ Opted out

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

_____

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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 $**100.00 fee** for all missed appointments ("no shows") and appointments that are cancelled without a compelling reason, without a 24-hour advanced notice. All EEG, EMG, and Botox appointments will be charged a **$200.00 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 may result in termination from our practice.

We appreciate all patients arriving early with paperwork completed for their scheduled appointments. However, you are more than 10 minutes late, your appointment may 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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HIPAA NOTICE OF PRIVACY

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;
• 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 healthcare 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 to 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 request 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. You may print your records at home from our portal without other charges.

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.

For Further Information: 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

_____ _____ _____

Print Patient Name Patient Signature Date

Insurance Disclaimer

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary" within your benefits. If your health insurance company determines that a particular service is not reasonable, necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. While we do try to run all eligibility and benefits prior to the appointment, we suggest to all patients that they contact their insurance to confirm that these services are covered and they are within the plans network. Under this arrangement, you are responsible for paying your co-pay, any non-covered portions, and any deductible you have yet to cover. In addition, if your insurance company does not pay for our services, you agree to pay for the services provided in our clinic.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my insurance is unable to be verified prior to the appointment, I may defer the appointment to a later date or I can opt to be seen at the self-pay rate. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I acknowledge that my insurance may be billed for specific phone calls, messages through the portal, and additional provider time. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, coinsurance, or unpaid balance that applies, including consent to patient care management, PCM, charges.

_____

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Medical Disclosure Form

Name:_____ DOB:_____

I hereby authorize the disclosure of my Quality Neurology medical information to the following individuals until otherwise revoked in writing:

Name/Relationship/Phone Number:

Name/Relationship/Phone Number:

Name/Relationship/Phone Number:

Emergency Contact

Name *Relationship* *Phone Number*

Do you have an Advance Directive? ___ Yes ___ No

If yes, please provide name and contact information of the healthcare surrogate.

Patient Signature