

Patient Signature



6800 NW 9<sup>th</sup> Blvd Ste 2 Gainesville, FL 32605



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

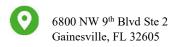
1717 SW Newland Way Lake City FL, 32025

## **Authorization to Release Medical Information**

I hereby Request and Authorize:				
Lucas Beerepoo	ot, MD, and Lindsay Falk, APRN of Quality Neurology			
To Obtain From: _				
To Release To:				
The Following Inform	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.				

Date







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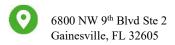
DOB: \_\_\_\_\_

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# Acknowledgement and Authorization

Patient Signature	Date				
By signing below, you acknowledge that you have read a	nd understand the policies listed above.				
Opted in: Send and Receive Documents	Opted out				
which could impact the coordination of your care and potentially	affect health outcomes.				
Please note: Opting out may limit our ability to access important	information about your health condition,				
through networks connected via the Interoperability Hub.					
Please select the appropriate consent option to authorize the	exchange of patient health information				
• I give my consent for care and treatment provided by	Quality Neurology LLC.				
• I authorize Quality Neurology LLC to obtain access t	to my medication history.				
• I have read and understand the Financial Policy for Q	Quality Neurology LLC.				
• I authorize Quality Neurology LLC to release medical information required to process my claim					
• I hereby assign my insurance benefits to be paid direct	ctly to the Healthcare Provider.				
• 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 have read and understand the HIPAA/Privacy Policy	y for Quality Neurology LLC.				







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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.

Print Patient Name	Patient Signature	Date
By signing this poli	icy, you acknowledge that you have received and understand	d this policy.



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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.					
	th Blvd Suite 2 Gainesville, Fl. 32605. This Noti	acy Officer by phone at (352) 478-4700 or at the ice of Privacy Practices is also available on our Quality			
Print Patient Name	Patient Signature	Date			
	Insurance Disclaim	er			
-	authorization does not guarantee payment or itations, and exclusions of the member's con	r verify eligibility. Payment of benefits are subject ntract at time of service.			
"reasonable and necessary" not reasonable, necessary, of that service. While we do tree contact their insurance to contact their insurance their	r that a particular service is not covered und y to run all eligibility and benefits prior to the onfirm that these services are covered and the asible for paying your co-pay, any non-cover	ce company determines that a particular service is ler the plan, your insurer will deny payment for he appointment, we suggest to all patients that they			
above, for the reasons stated appointment to a later date of agree to be personally and f phone calls, messages throu company does make payme	d. If my insurance is unable to be verified proof I can opt to be seen at the self-pay rate. If ully responsible for payment. I acknowledge gh the portal, and additional provider time.	my health insurance company denies payment, I that my insurance may be billed for specific I also understand that if my health insurance co-payment, deductible, coinsurance, or unpaid			
Patient Signature		Date			





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## **Medical Disclosure Form**

Name:		_DOB:
-		ogy medical information to the following
individuals until otherwise revoked in	n 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 conta	ct information of	the healthcare surrogate.