Adirondack Neurology Associates, PC
Patient Consent Form

1. Patient Consent to Treat

I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated, and which are deemed necessary by the provider in course of treatment.

2. Patient Consent for Use and Disclosure of Protected Health Information (PHI)

I, the undersigned patient, give my consent to the provider entity and its agents to use or disclose my protected health information (PHI) to carry out treatment, payment, or health care operations. These individuals and entities can release, use or disclose my PHI to other health care personnel including, but not limited to physicians, nursing staff, physical therapists, radiology personnel, student in each of the above disciplines, and other such entities or persons as are deemed related to treatment, payment, and health care operations, as determined in the sole discretion of the provider, his/her practice group, and their respective agents.

3. Permission to Release Medical Records to Providers

If another provider who is involved with my treatment, payment, or healthcare operations relating to me requests my medical records, I consent to the release of my entire medical record maintained by the provider to those requesting providers.

4. Permission to Release Billing Information Over the Telephone

I agree, as part of this consent for payment operations, that the provider, its group and their billing personnel can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or heath plan number. (Unless otherwise listed under Item 12)

5. Acknowledgement of Financial Responsibility

I acknowledge full financial responsibility for services rendered by the provider and that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I also understand that if I am a member of an HMO/PPO, a copay will be paid at time of service, and if I do not get prior authorization from my Primary Care Physician for services rendered, I am responsible for the bill. I further authorize and request that insurance payments be made directly to Adirondack Neurology Associates, PC, should they elect to receive such payment.

6. Permission to Call and Leave Voice Mail Messages

I agree that the provider or its agents or representatives may call and leave a voice mail message at my home or the number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment or healthcare operations.

7. Permission to Discuss Protected Health Information with Third Persons

I agree that the provider may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree the provider may discuss my PHI with any person that identifies him or herself as active in my mental, physical, emotional or spiritual care, including but not limited to family, friends, clergy, and patient advocates unless otherwise listed under Item 12. I also agree that the provider, his/her practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

8. Permission to Discuss Protected Health Information Regarding Minors

I agree that the provider, his/her practice group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.

9. Permission to Discuss Protected Health Information with Public Agencies

I agree the provider, his/her practice group, and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.

10. Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from this provider a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this providers' privacy practices and my right regarding privacy of my PHI. The terms of the "Notice of Privacy Practices" may change. If the provider changes its "Notice of Privacy Practices" I understand I may obtain a revised copy by contacting the provider's office. A copy of this "Notice of Privacy Practices" is located in the waiting room and is available to me at any time. I understand that I have the right to review the "Notice of Privacy Practices" prior to signing the consent.

11. Right to Restrict Protected Health Information: Right to Revoke Consent

I understand that I have the right to request that the provider restrict how my PHI is used or disclosed for treatment, payment or health care operations, and that the provider is not required to agree to this restriction. If the provider does agree to the restrictions, however, the provider is bound by such agreement. I also understand that I have the right to revoke this consent, in writing, except where the provider has already made disclosures in reliance on my prior consent.

12. Name(s) of Entities and/or persons NOT to disclose Protected Health Information to:

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_____

_____** To Be Signed Electronically at the Office**_____

Patient Signature or Personal Representative Date _____

Relationship if Personal Representative _____