EMG CENTERS OF CHICAGOLAND / NEUROLOGY CONSULTANTS, S.C.

Patient Agreements and Authorizations

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by Neurology Consultants, S.C. Physicians, Nurses or other designated health care providers. I understand that Physicians, Nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to such student involvement in my care.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: *I authorize* use and disclosure of my personal health information (PHI) for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the health care operations of Neurology Consultants, S.C.. *I authorize* Neurology Consultants, S.C. to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Neurology Consultants, S.C. may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. *I acknowledge receipt* of the physician's Notice of Privacy Practices (which provides detailed information about how the practice may use and disclose my confidential information). *I understand* that the physician has reserved the right to change his/her privacy practices that are described in the Notice. I also understand that a copy of any *revised* Notice will be provided or made available to me. *I understand* that this consent is valid until it is revoked by me and that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. *I understand* that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

ASSIGNMENT OF BENEFITS: In consideration of services rendered, I hereby assign and authorize direct payment to Neurology Consultants, S.C., any insurance, health plan or third party payor benefits otherwise payable to me or on my behalf for hospitalization, emergency room or outpatient services.

RESPONSIBILITY FOR PAYMENT: I acknowledge that I am responsible to pay for all copayments, coinsurances and all services not covered or denied by my insurance plan.

AT THE TIME OF SERVICE: All payment of copays, deductibles and non-covered services is expected at the time of service. Patients without insurance are expected to make payment (and/or payment arrangements) *prior to service*. Neurology Consultants, S.C. accepts the following in satisfaction of your obligation: cash or check. You will be charged a $25.00 fee when checks are returned for NSF (nonsufficient funds).

LATE CANCELLATION / NO SHOW: Failure to keep a scheduled appointment without a 24 hour notice may result in a $25.00 charge, or practice site's designated fee. In addition, our office reserves the right to terminate our relationship with you for missed appointments.

DISABILITY / FMLA FORMS: All patient disability & absentee documentation to be filled out by the physician requires a payment of $20.00 before forms will be completed and/or faxed.

1.) I will allow Neurology Consultants, S.C. to speak to the following individuals regarding my health information:

Spouse/Son/Daughter/Mother/Father/Sibling/Friend (circle relationship) Their Name:

2.) May we leave you a message regarding test results? Yes _____ No _____

Patient Signature (or Authorized Signature): Date:

If you are not the patient, please specify your relationship to the patient: _____