Consent, Assignment of Benefits and Acknowledgement of Privacy Practices

CONSENT FOR TREATMENT

I hereby voluntarily consent to care, treatment, testing, and all other services performed by healthcare providers at NeuroHealth Solutions' practices. I do understand that I have the right to refuse to consent to any proposed care, testing, treatment, surgery, or procedure. Moreover, I have the right to ask questions and discuss my concerns with my healthcare provider. I am aware that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees have been made to me as to the outcome of my care, examination, and/or treatment.

I understand that I am required to sign this consent annually or whenever necessary, although I may revoke this consent at any time by writing to NeuroHealth Solutions Medical Group, LLC, Attention Health Information Services at 10555 N 114th St, Scottsdale, AZ 85259

ASSIGNMENT OF BENEFITS AGREEMENT

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to NeuroHealth Solutions Medical Group, LLC for medical or surgical services or items rendered to me or my dependent by NeuroHealth Solutions Medical Group, LLC. Should my insurance carrier deny NeuroHealth Solutions Medical Group, LLC payment, I understand that I am financially responsible for the charges. I authorize NeuroHealth Solutions Medical Group, LLC to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

RELEASE OF MEDICAL INFORMATION

I understand that both electronic and paper based documentation of medical care received are maintained. This medical or health record typically includes information about my symptoms and health condition; results of physical examinations and diagnostic tests; a plan regarding future care and treatment; as well as demographic and photographic identifiers. Such individually identifiable information about me is protected health information (PHI) and, as such, will be used, shared, or disclosed only for the purpose of treatment, payment, and healthcare operations or as required by law. Otherwise, it will not be inspected or released without my specific authorization except in certain circumstances as outlined in the *Notice of Privacy Practices*.

Additionally, I am aware that data and information concerning essential medical treatment and healthcare services rendered on my behalf may be disclosed, when necessary, to healthcare providers in emergent situations and/or to public and private health insurance plans in order to receive payment as outlined in our Financial Policy. However, I may request that PHI associated with that portion of my healthcare for which I paid out-of- pocket in full not be disclosed to my health plan or insurance company. I understand further that this request must be in writing and submitted to Health Information Services.

NOTICE OF PRIVACY PRACTICES:I acknowledge I have received a copy of the *Notice of Privacy Practices* to review and a copy of the *Notice of Privacy Practices* is posted in both English and Spanish within the facility, on our website and a paper copy is available at the reception desk.

PATIENT RIGHTS & RESPONSIBILITIES:I acknowledge that my healthcare is a partnership between NeuroHealth Solutions and me; hence, I agree to actively participate and to accept both my role and responsibility with regard to my healthcare and the rights available to me. A list of patient rights and responsibilities is posted in both Spanish and English within the facility. A copy of this list is available to me upon request.

ADVANCE DIRECTIVES: Adults 18 years and older have the right either (a) to give directions about their future medical care or (b) to designate patient representatives to make medical decisions for them if they lose individual decision-making capacity. I understand that information about advance directives is available to me upon request.

ATTESTATION: I have read and now fully understand the content and references contained in this consent form in its entirety, and all of my questions have been answered to my personal satisfaction.

Patient Name: _____ Patient Representative: _____

Patient/Representative Signature: _____ Date:_____