Wesley Neurology Clinic, P. C.
Permission/Confidentiality/Assignment Form

Consent to Treat **Initial Here _____**

I am voluntarily seeking medical treatment. I consent to examination and treatment by the physicians, nurses and other health care professionals at Wesley Neurology Clinic, P. C. I also consent to any medical procedures, X-ray, EMG, EEG, MRI, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Medical Records **[ ] Accept [ ] Decline**

Medical records cannot be sent to your primary care physician or referring physician without written permission from you. To have any part of your records sent to your "PCP" or "RP" please initial above. By your initial (above) and signature (below) you are giving us permission to release your records to the physician/physicians listed on your patient registration form.

Test Results **[ ] Accept [ ] Decline**

Test results cannot be left on your answering machine or discussed with another family member, even if it is your spouse. If you want your results mailed, left by message on your phone or given to someone else you will need to sign this form and print the name of the person we may speak with in the space provided below. By your initial (above) and signature (below) you are giving us permission to release your test results as stated above.

Confirmation of Appointments **[ ] Accept [ ] Decline**

As a courtesy to you, we do call prior to the day of your appointment to confirm the time and date of your appointment. This information cannot be left on your answering machine or relayed to someone else without this written permission. By your initial (above) and signature (below) you are giving us permission to relay this information as stated above.

Discussion of Your Account/Payment Responsibility **[ ] Accept [ ] Decline**

We cannot discuss your bill with anyone without written permission (this includes your spouse or any other family member) unless they have a power of attorney letter on file. By your initial (above) and signature (below) you are giving us permission to discuss as stated above.

Acknowledgement of Notice of Privacy Practices **[ ] Accept [ ] Decline**

I am verifying that I have been given the privacy regulation form (HIPPA) which provides me with the information of how my Protected Health Information (PHI) is used.

Assignment and Release **[ ] Accept [ ] Decline**

I assign directly to Wesley Neurology Clinic, P. C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I agree that in the event of non-payment for services provided, to accept full and complete responsibility for the balance due, collection costs, court costs, as well as any attorney fees should that action become necessary. I authorize the use of my signature on all insurance submissions.

The above named facility may use my health care information and may disclose such information to the named insurance company or companies (as listed on the patient registration form) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient Name: _____ Date: _____/_____/_____

Signature: _____

(Signature of Patient, Parent, Guardian, or Personal Representative)

Permission to Speak With: _____/_____ (Relationship)