Wesley Neurology Clinic, P. C.
Authorization for Use or Disclosure of Health Information

Please PRINT or TYPE and return completed form to the address at the bottom of this page.

Patient Name: ______________________ Patient Phone Number: ______________

Patient Address: ____

City: ____________________ State: __________ Zip Code: ______________

Date of Birth: ____/____/____ Social Security Number: ______-______-______

1. With regard to the information identified in Section 3 below, I authorize Wesley Neurology Clinic, P. C. to _____ **send** or _______ **obtain (please mark one)** information to and/or from the healthcare provider or organization listed below:

Physician/Facility Name: ______________________________________

Physician/Facility Address: ____________________________________

City: ____________________ State: __________ Zip Code: ______________

Phone Number: ( ) _______-_________ Fax Number: ( ) _______-_________

2. The purpose for which the information is being disclosed:

____

3. I authorize the disclosure of the following information from my medical record:

( ) Complete Medical Record ( ) Laboratory Results ( ) Progress Note ( ) Test Results

( ) Other (please specify): ______________________________________

4. I understand that I have a right to revoke this authorization at any time by presenting my written revocation to Wesley Neurology Clinic, P. C. I understand that the revocation will not apply to information that has already been used or released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate in one year.

5. I understand that I can refuse to sign this authorization. I need not sign this form in order to obtain treatment, payment, or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient and that the information may no longer be protected by federal confidentiality rules. I am also releasing this office of any responsibilities related to the faxing of those records. If I have any questions about uses or disclosures of my health information, I can contact Wesley Neurology Clinic, P. C. at:

East Office:
8000 Centerview Parkway, Suite 305
Cordova, TN 38018
(901) 261-3500

North Office:
3950 New Covington Pike, Suite 270
Memphis, TN 38128
(901) 261-3500

______________________________ ______________________________ __________
Signature of Patient or Personal Representative | Printed Name of Patient or Personal Representative | Date

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

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

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

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

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

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

No-Show Policy: — [ ] Accept

A "no-show" fee of $25.00 for any appointment will be applied to the patient's account on that day. Payment in full will be required prior to future appointments. If a patient accumulates 3 "No-shows", he or she may be asked to leave a credit card on file for any "no show" fee.

Patient/Visitor Audio and Video Recording Policy: — [ ] Accept

To ensure confidentiality and privacy, any type of video or audio recording is strictly prohibited in our office. If any staff member becomes aware of a patient or visitor using an audio or video recording device, the patient or visitor will be asked to cease the recording. If the patient or visitor refuses to cease recording, the patient may be terminated from the practice.

Assignment and Release — [ ] Accept

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. In the event my account is placed with a Collection Agency, a collection fee of up to 33.3% may be added to my account and shall become a part of the Total Amount Due. I will be responsible for any and all cost of collection including attorney fees and court cost. 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)**

Patient Agreement for the Prescription of Controlled Substances

The purpose of this Patient Agreement for the Prescription of Controlled Substances ("Agreement") is to prevent misunderstandings about medicines that you will be taking for pain management, and insure that you and your physician comply with all laws regarding the prescription and use of controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this agreement; and, that if I break this agreement, my doctor may stop prescribing pain-control medicines for me and may terminate me from further treatment at Wesley Neurology Clinic or by any other physician employed at Wesley Neurology Clinic.

I agree to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

Females only – I certify that I am not pregnant. I agree and understand that it is my responsibility to notify my doctor if I believe I may be pregnant. I agree not to take any medication without a physician's approval if I become pregnant.

I will not use any illegal controlled substances (including marijuana, cocaine, or heroin), unless prescribed by my physician.

I will not share, sell, or trade my medications with anyone. I will bring all unused pain medication to every visit.

I will not attempt to obtain controlled medicines, stimulants, or anti-anxiety medicines from anyone else.

I will safeguard my medicine. No allowance will be made for lost or stolen medicine or prescriptions.

I agree that refills of my prescriptions for pain medicines should be obtained only during routine office visits. It is understood that emergency refill requests may only be obtained during regular office hours (8:30 to 4:30 M-F). NO refills will be available after hours, on weekends or holidays.

I agree to use ONLY the following pharmacy for filling prescriptions of all controlled substances:

____

Pharmacy Name **Address** **Phone Number**

I authorize the doctor and my pharmacy to cooperate with any city, state, or federal law enforcement agency, or the board of pharmacy in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that if it is required to determine my compliance with the pain management program and this agreement, I will submit to random drug testing, at my expense.

I agree that I will use my medicine at a rate no greater than the prescribed rate and I understand that the use of my medicine in a greater rate may result in my death.

I attest that the above guidelines have been fully explained to me and that my questions and concerns regarding my treatments have been adequately answered. I have been given a copy of this agreement.

This agreement is entered into on (date): ______________________

Patient Signature: ______________________

Physician Signature: ______________________

North Office: 3950 New Covington Pike, Suite 270, Memphis, TN 38128
East Office: 8000 Centerview Parkway, Suite 305, Cordova, TN 38018

WESLEY NEUROLOGY PATIENT PORTAL CONSENT FORM

Wesley Neurology is offering this secure, confidential communication tool as a courtesy to our patients. It is an optional service, and we may suspend or terminate it at any time and for any reason. By signing below, you acknowledge that you have read and fully understand the policies, guidelines, and limitations of the Patient Portal and understand the risks associated with online communications and consent to the conditions outlined herein. You acknowledge that using the patient portal is entirely voluntary and your access will not impact the quality or current level of care you receive from Wesley Neurology. In addition, you agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that may be imposed for online communications. You understand that this agreement will remain in effect for 12 months unless sooner modified or terminated by either party. It is your responsibility to notify Wesley Neurology if there is a change to your email account or you feel that your secure password has been breached. Secure messaging and information can only be viewed by someone entering to correct username and password to log into the Patient Portal site. We will assign you this login information upon completion of this form. You agree not to hold Wesley Neurology or any of its staff liable for network infractions beyond their control.

Please print all information clearly

Patient Name: ______________________________ Date of Birth: ______________

Confidential email address*: ____

(*Please provide a personal email address to which you have consistent, frequent access; DO NOT use your workplace email)

Care Manager email address**: ____

(**Spouse/family representative accessing and managing patient's portal account/parent accessing child's portal account)

____ ______________

Patient Signature Date

____ ______________

Care Manager Signature Date

Care Manager Relationship to Patient: ______________________________________