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

<u>Medical Records</u> ○ 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/s listed on your patient registration form.

<u>Test Results</u> ○ 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 leave the name of the person we may speak with. By your initial (above) and signature (below) you are giving us permission to release your test results as stated above.

<u>Confirmation of Appointments</u> ○ 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.

<u>Discussion of Your Account/Payment Responsibility</u> ○ 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.

<u>Received Information</u> ○ Accept ○ Decline

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.

<u>Assignment and Release</u> ○ 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 as well as collection fees or interest that may be added if the account should be placed with an outside collection agency. 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)