NORTH SHORE NEUROLOGY & EMG, LLC – NEW PATIENT CONSENT FORM

CONSENT FOR RELEASE OF INFORMATION

As a patient in our practice, from time to time we may need to communicate with you or with physicians involved in your care, when you are not in the office. To preserve your privacy, we would like you to indicate your preferred method for us to communicate information to you and ask your permission to communicate with your physicians.

In the event that no one is available to answer your phone we need your permission to leave medical information pertaining to your care. We will not leave a detailed message regarding medical information if your name or phone number is not on your recorded message to identify your residence. Without specific permission we will not release any of your medical information to another person. In some cases you may wish for another person to have access to your medical information. Please indicate the full name and relationship of persons you authorize us to discuss your care with. (i.e. spouse, parent, sibling etc.)

By acknowledging signature I am authorizing North Shore Neurology & EMG to make available necessary medical information to all physicians involved in my care, family members/friends listed above. I assume responsibility to inform the practice of changes in my phone numbers(s) or my preference.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to North Shore Neurology & EMG, LLC I authorize North Shore Neurology & EMG, LLC to release any medical information requested by my health insurance carrier or any other third-party payer needed for any claim consideration; as well as to obtain any information concerning coverage and payments under my insurance policy. If I am without health insurance, payment for the office visit is required at time of service. Additional services will be billed to me. After 120 days, if a personal balance remains without a payment agreement, your account will be referred to our collections agency.

Non-Emergency Services provided without **Referral** Authorization: I understand that I have an obligation to obtain a referral for non-emergency services from my primary care physician prior to any and all appointments at North Shore Neurology & EMG, LLC.

I am responsible for all deductibles, co-insurances, and non-covered services. I understand that if this office does not participate with my insurance plan, I am responsible for payment of any balance not covered by the nonparticipating insurance carrier.

NOTICE OF PRIVACY PRACTICES

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at North Shore Neurology & EMG, LLC who may need to access to your information must abide by the Notice of Privacy Practices. All subsidiaries, business associates (e.g. billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes, or health care operations described in the Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

Your health care provider must give you a notice that tells you how they may use and share your health information and how you can exercise your health privacy rights. The provider cannot use or disclose information in a way that is not consistent with their notice. The law requires your doctor to state in writing that you received the Notice of Privacy Practices.

MISSED APPOINTMENT POLICY

All patients are required to give at least 24 hours advanced notice when cancelling an office consult appointment and 72 hours advanced notice when cancelling an EMG or 3 day video EEG. A missed appointment is defined as any appointment for which a patient does not arrive for as scheduled ("no show"), or is cancelled within the minimum notice listed above (same day cancellation). Patients with insurances, other than Medicare and Medicaid, which are in danger of dismissal, have the option to pay a $100 deposit that will be refunded if they show for the appointment timely; otherwise the deposit will be non-refundable.

ASSIGNMENT OF BENEFITS: I and/or my insurance carrier(s) agree to pay, in a timely manner, for health care services provided. I authorize payment directly to North Shore Neurology & EMG all benefits payable.

RELEASE OF INFORMATION: North Shore Neurology & EMG and/or physicians who provide professional services to the patient are authorized to furnish medical information from my emergency medical record to the referring physician, if any, and to any insurance company or third party payer for the purpose of obtaining payment of the account. North Shore Neurology & EMG is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.

FINANCIAL RESPONSIBILITY: In consideration for the telehealth services rendered to me, I agree to pay the charges not covered by any insurer or third party payer, including any deductible or co-payment, or any charges not covered under my plan and/or as a result of my failure to provide notification or obtain preauthorization for treatment as required by any insurer or third party payer to North Shore Neurology & EMG. Should my account be referred for collection, I agree to pay North Shore Neurology & EMG reasonable attorney fees and collection expenses.

CONSENT FOR TREATMENT: I hereby consent to the use of the information I supply as part of the Tele-visit interview by physicians, non-physician advanced practice clinicians (e.g. nurse practitioners, physician's assistants and other advanced clinicians licensed to provide health care services in the State of Massachusetts), and/or other specialists to assess my condition and recommend an appropriate course of care.

TELEMEDICINE/TELEHEALTH POLICY

North Shore Neurology & EMG Tele-visit Program affords patients the opportunity to complete Televisit appointments from the comfort of their own home or any appropriate internet access point. The program is open to select patients who meet the requirements to complete the tele-visit appointments.

The interactive video communications and/or by the electronic transmission of information may assist in the evaluation, diagnosis, management and treatment of a number of health care problems. This process is referred to as “telemedicine” or “telehealth.” This means that you may be evaluated and treated by a health care provider or specialist from a distant location. Since this may be different from the type of consultation with which you are familiar, **it is important that you understand and agree to the following statements:**

1. I acknowledge that North Shore Neurology & EMG tele-visits are for routine, non-urgent medical conditions, and are not designed, intended, or appropriate to address serious, emergent, or life-threatening medical conditions. I will not attempt to use my tele-visit to address these conditions. If I am having a medical emergency, I will discontinue my tele-visit and call 911 or go to the nearest emergency department. If I am experiencing significant pain, breathing trouble, dehydration, or any other distress that requires immediate or urgent attention, I will discontinue my tele-visit and call 911 or go to the nearest emergency department.
2. I acknowledge that I have agreed to comply with the requirements of this program and understand that the selection to participate, and continued participation, is subject to the program requirements and periodic review by the treating provider, staff, and administration. The Provider reserves the right to refer me back to an in-person visit if conditions change or because of non-compliance.
3. I acknowledge that I will be asked questions regarding the condition for which I am seeking medical care, and that I am obligated to answer questions truthfully.
4. I agree that I will answer these questions completely and accurately and that, if I cannot understand a question or do not know the answer to a question, I will stop my Tele-visit and schedule an in-person visit.
5. I voluntarily consent to health care services provided by my doctor(s) or a designee, which may include diagnostic tests, drugs, examinations, and medical or surgical treatments considered necessary to treat my health problem.
6. I acknowledge that I should be in a secure environment (not a restaurant, lobby, etc.) for the visit, and that it is my responsibility to ensure the privacy of my information on my computer/device.
7. I acknowledge, If my insurance does not cover this service, that I have agreed to "self-pay" for these specific Tele-visit services provided to me through North Shore Neurology & EMG, and I will be responsible for payment in full via a credit card. I would be responsible for the charge of $75.00 for an established patient and $150.00 for a new patient consultation.
8. I acknowledge that I am solely responsible for maintaining the safety and security of my login ID and password.
9. I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make arrangements for follow-up care.
10. I understand that my Tele-visit provider is not able to provide care for all conditions, and I may need to schedule an in-person appointment with a provider.
11. I acknowledge that I have read and understand this disclaimer, Hale Health terms and conditions, and privacy policy that apply to the Tele-visit made available through the Hale Health software platform.
12. I understand that I have the option to refuse telehealth service at any time without affecting the right to future care or treatment.

I voluntarily consent to the above policies, physician care, including physician examination, tests and to medical treatment that may be necessary in the judgment of my physician and/or assistants and designees. This form has been explained to me and I certify that I understand its content.

_____

Patient Printed Name

_____/_____ /_____

Date of Birth

_____

Signature of Patient/Representative Date