Neurology Associates of Fredericksburg

Authorization to Release Information
I authorize the release of any medical or other information to my insurance carrier(s) or to any entity necessary to determine insurance benefits or the benefits payable for related healthcare services and/or supplies provided by Neurology Associates of Fredericksburg.

Initial Here: _____

Assignment of Benefits
I authorize direct payment of all insurance benefits, including Medicare, to Neurology Associates of Fredericksburg for all covered healthcare services and supplies provided to me by Neurology Associates of Fredericksburg and/or its affiliated entities. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Neurology Associates of Fredericksburg and will constitute a continuing authorization, maintained on file with our office, which will authorize and allow for direct payment of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Neurology Associates of Fredericksburg.

Initial Here: _____

Notice of Patient Privacy Practices
I acknowledge that I was provided the opportunity to review a summary of Neurology Associates of Fredericksburg's Notice of Privacy Practices (NPP). I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice and may receive a complete copy of the NPP upon request. I understand I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial Here: _____

HIPAA Consent
I understand that HIPAA requires Neurology Associates of Fredericksburg doctors and staff to verify identities when speaking with unknown family members and friends. I understand the doctors and staff of NAI may not have access to this disclosure information at certain times such as after-hours and on weekends, and I agree they should use their professional judgment and discretion at such times with respect to sharing my personal health information, including emergency situations where I may be unable to provide consent. I also understand that Neurology Associates of Fredericksburg may request and release information to and from treating providers as well as new referrals for necessary treatment.

Initial Here: _____

Disclosures related to my health or as needed for payment for health care services may be made to the following family members and friends:

NAME	PHONE NUMBER	RELATIONSHIP	DATE OF BIRTH

May we call you at your place of employment? **Yes / No**

May we leave leave a message on your office voice mail? **Yes / No**

May we leave medical information, such as testing results & medication changes, on your home voice mail? **Yes / No**

I acknowledge the above information has been explained to me and I understand it.

SIGNATURE	
PRINTED NAME	
DATE	