Robin Warner
NEUROLOGY

drrobinwarner.com • Phone: (201) 719-5910 • Fax: (682) 255-1158

CONSENT AND ACKNOWLEDGMENT OF TREATMENT AND SERVICES

GENERAL CONSENT TO TREATMENT

By signing below, I authorize the health care providers at Robin Warner Neurology, PLLC ("the Practice") to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services, or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, procedures, or tests. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, side effects, or reasonable alternatives to the procedures or tests. This General Consent to Treatment form does not take the place of an informed consent form for a particular procedure or test.

A. Right to Refuse Treatment.

I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my treating health care provider(s).

B. Medical Education and Participation of Students and Trainees.

I understand that authorized, appropriately supervised students and trainees may observe and assist in my treatment and care, unless I expressly object to their participation in my health care.

I acknowledge and agree that this consent/acknowledgment will be applicable to all visits or instances of treatment by the Practice.

By initialing below, I acknowledge that I have read and understand the above information.

[Initials of patient]

SECTION TWO.
RESPONSIBILITY FOR PAYMENT

By initialing below, I understand and acknowledge that I am financially responsible for paying all costs associated with the health care services I receive from the Practice. I understand that I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance, including deductibles and co-payments. Unless I pay personally in full for services, I understand that health information about me may be shared with my health insurance carrier(s) or other third party payers responsible for paying for my health care.

By initialing below, I authorize the Practice to share information about me, with my health insurers, unless I pay personally in full for my services, in order to be paid for the services they have provided. I

agree that the patient named in this form (myself or another over whom I have legal authority) is covered by the insurer(s) that I have shared with the Practice, and that I have received no notice of discontinuation of benefits.

I acknowledge and agree that this consent/acknowledgment will be applicable to all visits or instances of treatment by the Practice.

By initialing below, I acknowledge that I have read and understand the above information.

[Initials of patient]

SECTION THREE.
MINORS

If you are a minor who consents to health care services on your own behalf but use your parent's or guardian's insurance policy to pay for your services, please know that your parent or guardian will receive an Explanation of Benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. Please speak with our staff if you wish to pay for your services in another manner.

I acknowledge and agree that this consent/acknowledgment will be applicable to all visits or instances of treatment by the Practice.

By initialing below, I acknowledge that I have read and understand the above information.

[Initials of patient]

SECTION FOUR.
NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been given the Notice of Privacy Practices.

Dated: _____

_____
Signature

_____
Print Name

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CONSENT TO TREATMENT BY TELEHEALTH

By signing below, I authorize the health care providers at Robin Warner Neurology, PLLC ("the Practice") to conduct certain examinations to assess my health care conditions via telehealth. Telehealth is a way to visit with my healthcare provider from any place, including my home or office. You talk to your provider by phone, computer, or tablet. I understand that my telehealth appointment will take place via my computer, phone or tablet and that my provider may use video to facilitate my treatment. I further understand that my provider will not be in the same room as me and there may be limitations to my treatment as my provider cannot examine me as closely as at an office visit. Technical problems may interrupt or stop my visit at any time. During the course of my telehealth treatment my provider may decide that I need an in person visit to better meet my needs. I understand that a telehealth visit will not cost any more than an office visit. What I pay depends on my insurance.

Telehealth Privacy
The Practice will not record visits with your provider. I understand that due to the nature of telehealth treatment, if people are close to me, they may overhear my treatment. It is my responsibility to ensure I am in a private place, so other people cannot hear me. My provider will tell me if someone else from the Practice can hear or see me.

The Practice utilizes telehealth technology that is designed to protect your privacy. With that in mind, If you use the Internet for telehealth, we recommend that you use a network that is private and secure.

Right to Refuse Telehealth
I understand that by signing this form I am consenting to the use of telehealth. I further understand that I am in no way required to consent to treatment via telehealth and can request an in-office visit at any time, including during a telehealth visit. By signing this document, I agree that my provider and I talked about the information in this document and that I had an opportunity to ask questions related to the use of telehealth in my treatment.

Dated: _____

_____
Signature

_____
Print Name

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FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our payment policies.

1. Insurance.
   We do not participate in most insurance plans, including Medicaid. You may request a superbill to submit to your insurance company for reimbursement (commercial insurance carriers only, not Medicare and Medicaid). However, we cannot guarantee reimbursement and we cannot speak to your insurance company on your behalf. Payment in full for each visit is required at the time of treatment. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. By signing below, you indicate that you understand and acknowledge that you are financially responsible for paying all costs associated with the health care services you receive from Robin Warner Neurology, PLLC. You understand that you may be financially responsible for such costs even if you have health insurance, depending on the benefits and coverage limitations of your health insurance policy. You understand that you are also financially responsible for charges not covered by your health insurance, including deductibles and co-payments or co-insurance.

2. Co-payments and Deductibles.
   All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. Payment by Credit Card
   For your convenience we accept Visa, Mastercard, American Express, and Discover cards. Your card will be charged at the time of your appointment. The use of a credit card on file and/or credit card preauthorization is a convenience that the patient may elect to utilize, although it is not a condition to treatment. Patient understands that by using a credit card, you may be foregoing state and federal protections regarding medical debt.

3. Non-Covered Services.
   Be aware that some and perhaps all of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

4. Proof of Insurance.
   All patients must complete our patient registration form before having an exam. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in time to meet your insurance company claim filing limit, you will be responsible for the balance of the claim.

5. Claims Submission.

Your insurance company may need you to supply certain information in order to process your claim. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Non-Payment.

If your account is over 60 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area. Let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Dated: _____

_____
Signature

_____
Print Name

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. For more information about our privacy practices or additional copies of this Notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment:

We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment:

We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations:

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization:

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends:

We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Persons Involved in Care:

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services:

We will not use your health information for marketing communications without your written authorization.

Required by Law:

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect:

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security:

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders:

We may contact you to provide you with appointment reminders via voicemail, postcards, or letters.

PATIENT RIGHTS

Access:

You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting:

You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction:

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Alternative Communication:

You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide

satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment:

You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.