Consent for Treatment

Consent for Treatment/Care

I consent to treatment and care by Center for Neurosciences and by their physicians and health care providers. I also consent to treatment and care by physicians and health care providers who are not employees or agents of Center for Neurosciences, but are authorized by Center for Neurosciences to provide treatment and care to me as a patient. I understand that my care team at Center for Neurosciences may include resident physicians or other trainees.

Consent for Use and Release of Information

I give permission to Center for Neurosciences – including its treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); or (3) for the health care operations of the Center for Neurosciences. For more detailed information about the way my information may be used or released, I can read the Center for Neuroscience's *Notice of Privacy Practices.*

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. I agree to pay interest at 1.5% per month on balance determined not to be the insurances responsibility and that are more than 90 days past due. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate Center for Neurosciences on my behalf. I authorize Center for Neurosciences to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the Center for Neurosciences.

Patient Name: ____ **Date of Birth:** ____________

Patient Signature: ____ **Date:** ___________________

(or Authorized Representative)

Revised 01/08/2016