PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

Patient Consent Form and Clinic Policies

I, _____ give my signed consent to PEAK Neurology and Sleep Medicine, LLC to provide me services, including office consultation, physical examination, and/or treatments considered necessary and in my best interest. I understand that my consent is necessary before PEAK Neurology and Sleep Medicine, LLC can provide services to me. I further understand that this consent shall remain in effect until retracted by me in writing to the physician and/or healthcare provider.

By initialing I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Initial

Assignment of Benefits, Release of Billing Information

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/ medical plan, to issue payment check(s) directly to PEAK Neurology and Sleep Medicine, LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize PEAK Neurology and Sleep Medicine, LLC to: (I) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from PEAK Neurology and Sleep Medicine, LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

By initialing I acknowledge that I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____
Initial

Patient Financial Policy

Insurance Coverage and Benefits

- Although we are preferred providers for many insurance carriers, it will be your responsibility to contact your insurance company to check your benefits specific to your plan for out-of-network insurance carriers.
- Your insurance policy is a contract between you (and/or your employer) and your insurance company. As a service to you, we will file your insurance claim. If you have more than one insurance plan, be sure we know who they are; we will file secondary and tertiary insurance claims for you if notified promptly.
- If you have a co-pay or deductible you will make payment on that amount at the time of service.
- If your insurance company does not pay the claim within 90 days of the date of service, payment will become your responsibility.
- If we receive a payment from your insurer resolving your account after you have paid it in full, we will refund any patient overpayment to you.
- Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," or over their "allowable" amount, you will be responsible for payment of the balance remaining. It will be your responsibility to have quality communication with your insurance carrier or your employers' human resources department.

Self-Pay

- Self-pay patients that pay in full at the time of service will be given a 10% discount. All patients will be considered self-pay until verification of an active insurance policy has been confirmed (e.g. a current copy of an insurance card) has been brought to the office.

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Payment Plans and Collections

▪ For your convenience, we accept Visa, MasterCard, American Express and Discover.
▪ We recognize that accounts with large balances may require an extended payment period. Please contact us for further details to make payment arrangement. Note that once we agree to a payment plan, you have committed to make monthly payments.
▪ We reserve the right to send your account to collections without notice if you miss a scheduled payment without communicating with our office.
▪ If you are unable to meet your financial obligation, you may make financial arrangements with our office or apply for assistance not to exceed 6 months. Please do so before your account is in arrears.
▪ If you are granted assistance and neglect to adhere to your payment plan, your account will be sent to collections with the original (pre-assistance) amount due.
▪ Any balances left outstanding after 90 days will be referred to a 3rd party collection agency, and a $10 collections fee will be added to the account. To avoid collection activity, payment in full is due upon receipt of the billing statement.

Third Party Claims

▪ If you have a liability claim such as worker's compensation or a liability claim you will be responsible for providing the claim number, and authorization for treatment.
▪ In some instances, benefits are exceeded or the claim may expire. In such cases, you will be considered a self-pay patient, and payment in full will be required at the time of service.
▪ In the event, you are part of an auto accident or other liability claim awaiting settlement, you will be considered self-pay and payment in full will be required at the time of service. Peak staff may accommodate you with a receipt so that you can submit for reimbursement from the carrier responsible for your claim.

By initialing I acknowledge that I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____
Initial

Cancellation and No Show Policy

We do require a 24-hour notice for cancellations. A cancellation less than 24-hours prior to your scheduled appointment is considered a short notice cancellation. We offer a courtesy warning the first time you short notice cancel or no show for your scheduled appointment. Our office staff will reschedule your appointment making you aware that if you short notice cancel or no show for a future appointment with our office will require a deposit of $50.00. If your appointment is for a sleep study the fee is increased to $100.00. This deposit will be required for all future appointments. If you keep your appointment as scheduled, the deposit will be applied to your appointment.

In an effort to maximize our schedules we ask that you notify our office within a 24-hour time frame if you are unable to keep your appointment. This gives us time to schedule other patient who are waiting for an appointment. If you are unable to meet these requirements you will be considered a No Show and subject to a $50.00 charge to reschedule your appointment. If your appointment was for a sleep study, you will be subject to a charge of $100.00 prior to rescheduling this appointment. This fee is charged directly to you the patient, not your insurance company, and is due prior to scheduling your next appointment. In the event of a second no show you may be dismissed from the clinic. New patients who fail to show for their initial appointment will not be contacted to reschedule.

As a courtesy we do make reminder calls for appointments. However, in the event that you do not receive a reminder call or message, the No Show policy remains in effect.

We do understand there are times where unforeseen circumstances may create a situation where 24 hours' notice may not be possible. This can be discussed with management and the No Show charge may be waived. If you have any questions regarding our no-show policy, please feel free to speak with one of our patient care coordinators and they would be more than happy to review this policy with you. We appreciate you trusting PEAK Neurology and Sleep Medicine with your medical care.

By initialing I acknowledge that I have read and agree to the above stated cancellation and no-show policy.

_____
Initial

By signing below I acknowledge I have read and understand the above policies:

_____ _____
Patient name (please print) Date

_____
Patient or guardian signature

_____ _____
Patient guardian name (please print, if applicable) Guardian relationship to patient

PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

Authorization for medication history

Patient name _____ Patient Date of Birth _____

Patient address _____ Patient SSN _____

I am the patient or the authorized representative of the patient named above. I request that health information regarding my/ the patient's care and treatment be released as set forth on this form. In accordance with Alaska Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. Peak Neurology and Sleep Medicine, LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between medical providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am/the patient is currently taking and/or have/has taken in the past. This information will be utilized by Peak Neurology and Sleep Medicine, LLC for my/the patient's medical care.

2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Peak Neurology and Sleep Medicine, LLC

3. I have the right to revoke this authorization at any time by writing to Peak Neurology and Sleep Medicine, LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary and I may refuse to sign. My/the patient's treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.

6. This authorization will expire one (I) year after the date of my signature below, unless I have checked or filled in a different expiration date. Other: _____

7. THIS AUTHORIZATION DOES NOT AUTHORIZE PEAK NEUROLOGY AND SLEEP MEDICINE, LLC TO DISCUSS MY/THE PATIENT'S PROTECTED HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient signature _____ Date _____

Guardian signature (if applicable) _____ Guardian relationship to patient _____

PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

HIPAA Waiver

(Patient consent to Release Protected Health Information)

I, _____ hereby authorize PEAK Neurology and Sleep Medicine, LLC to release my medical information to:

_____

This release expires one year after the date of signing (or on: _____) I also understand that I have the right to revoke this release at any time.

Please initial next to each selection that applies:

_____ Billing
_____ Medical Record
_____ Verbal Information
_____ Entire Chart
_____ Other

_____ _____
Patient date of birth Date

_____ _____
Patient signature Witness signature