PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

PATIENT CONSENT, RELEASE OF INFORMATION, ACKNOWLEDGMENT OF PATIENT POLICIES

Patient Name: _____ Patient Date of Birth: _____

Print name of Patient's Guardian or Authorized Representative Signing this Form: _____

Please read and initial each section and sign on last page.

Consent to Health Services

I consent and agree to routine diagnostic procedures, medical treatment, and other health and medical services provided by Peak Neurology and Sleep Medicine, LLC ("Peak") to me or the patient named above.

I understand that:

- The practice of medicine is not an exact science, and that diagnosis and treatment involves risks of injury and sometimes death. I acknowledge that there are no guarantees about results of the examination, treatment, or other health care services provided by Peak.
- Except in emergency situations, no procedures are performed on a patient unless and until the patient has had an opportunity to discuss the risks and benefits of the procedure to the patient's satisfaction.
- Each patient has the right to consent or refuse to any proposed procedure or treatment plan.
- No patient will be involved in any research or experimental procedure without the patient's full knowledge and consent.

_____
Initials

Notice of Privacy Practices

By initialing below, I acknowledge that I have reviewed and agree to Peak's Notice of Privacy Practices, which explains how my (or the patient's) medical information will or may be used and disclosed. I understand that I am entitled to receive a copy of Peak's current Notice of Privacy Practices at any time.

_____
Initials

Continued on next page

Release of Information

I consent to the release of all my (or the patient's) financial, medical, and demographic information necessary to process my (or the patient's) insurance claims.

I consent to the release of my (or the patient's) medication history by Peak to 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 all prescription drugs I am (or the patient is) currently taking and/or have/has taken in the past. This information will be used by Peak for my/the patient's medical care. 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.

I understand that I may revoke this consent, or any part of it, in writing at any time.

_____
Initials

Assignment of Benefits

By initialing below and signing this form, I hereby assign my (or the patient's) insurance benefits to Peak and authorize payment directly to Peak of amounts otherwise payable to me (or the patient) from private insurers and public payers for services rendered to me (or the patient) by Peak.

I authorize Peak to file an appeal on my (or the patient's) behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan will not direct payment to Peak, I agree to forward to Peak all health insurance payments which I receive (or the patient receives) for the services rendered by Peak.

I authorize Peak or any holder of medical information about me (or the patient) to release to my (or the patient's) health insurance plan such information needed to determine these benefits or the benefits payable for related services.

_____
Initials

Statement of Financial Responsibility

I understand that:

- By accepting health care services from Peak, I am agreeing to be fully responsible to pay for all services and products provided to me (or the patient) from Peak.
- If I have (or the patient has) health insurance, the insurance policy is a contract between me (or the patient) and the insurance plan/company. As a courtesy, Peak will submit a claim to the health insurance company for services rendered by Peak, but I remain financially responsible to pay for all services rendered by Peak.
- I am responsible for and will pay all charges for services provided by Peak to me (or the patient) that are not covered by insurance or for which I am (or the patient is) responsible for payment under the insurance plan.
- Peak accepts payment by cash, check (with appropriate identification), Visa, MasterCard, American Express, and Discover.
- All Peak patients are considered self-pay until Peak has received verification of an active insurance policy. Patients with a worker's compensation, automobile accident, or other third-party liability claim are considered self-pay.
- If the account is more than 90 days past due, it may be charged interest at the legal rate.
- Peak will send my (or the patient's) account to collections if Peak does not receive payment in full within 180 days of date of service. If my (or the patient's) account is sent to collection, I (or the patient) will be charged and responsible to pay additional collection fees.

It is my responsibility to:

- Pay my (or the patient's) account in accordance with Peak's regular rates and terms.
- Promptly notify Peak of all insurance plans under which I am (or the patient is) covered and provide information for Peak to verify such coverage(s).
- Promptly notify Peak and provide all relevant information regarding any third-party liability claim I (or the patient) might have such as workers compensation, automobile accident.
- Determine in advance whether Peak is a preferred provider with my (or the patient's) insurance plan. If I don't know, I should ask Peak prior to receiving services from Peak.
- Pay at the time of services any co-pay, deductible, coinsurance, and/or for non-covered services for which I am responsible under the plan(s).
- Pay any balance still owing 90 days after Peak submits a claim to insurance. I understand that Peak will reimburse me if Peak receives payment from insurance after I have paid in full.
- Contact Peak if I am not able to pay my (or the patient's) account in full and need to set up a payment plan.

_____

Initials

PEAK NEUROLOGY
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Appointment/No Show Policies

Patients who need to cancel an appointment should notify Peak at least 24 hours in advance.

For appointments canceled less than 24 hours in advance, a $50 fee will be charged to reschedule an appointment, or a $100 charge if the appointment was for a sleep study. This charge is due before the patient's next/rescheduled appointment.

If a patient is late for an appointment, the appointment may need to be rescheduled. If so, a cancellation fee will be due before the rescheduled appointment.

_____
Initials

_____ _____
Patient Signature Date

_____ _____
Or legal representative (please print) Guardian relationship to patient

_____ _____
Witness Date

PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

HIPAA
(Patient Authorization to Release of Protected Health Information)

_____ _____
Patient name Patient Date of Birth

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

Individual name	Relationship to patient	Phone number

(If you are filling this out on behalf of the patient **and** are authorized to obtain medical information, please include yourself)

This release expires one year after the date of signing (or otherwise 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
_____ Entire Chart
_____ Other; Explain:
_____

For any of my information I have authorized to be released, I authorize Peak Neurology and Sleep Medicine, LLC to release such information to the authorized individual orally (for example, over the telephone or in person) and/or in writing.

_____ _____
Patient signature Date

_____ _____
Or legal representative (please print) Guardian relationship to patient

_____ _____
Witness Date