Acknowledgment

I acknowledge that I am aware of **Central Nebraska Neurology's** Notice of Privacy Practices, which describes how my health information may be used or disclosed. Central Nebraska Neurology reserves the right to change the Notice and its privacy practices at any time.

Signature _____ **Date** _____

Patient unable to sign because _____

Medical Records Release Authorization Exception

By my signature above, I understand that the physicians and staff of Central **Nebraska Neurology, P.C.** will not discuss my protected health information with anyone not covered by our Notice of Privacy Practices without my authorization. This includes family and friends; I hereby authorize the exchange of information with the following:

Name _____ **Relationship** _____ **Phone Number** _____

Name _____ **Relationship** _____ **Phone Number** _____

Name _____ **Realtionship** _____ **Phone Number** _____

Message Authorization

☐ Please initial if you authorize the provider/clinic to leave a message on my HOME/CELL/WORK Phone or answering machine/ or with another party living there, pertaining to the following (check all that apply):

	HOME/CELL	WORK
Date and time of upcoming appointment	☐	☐
Labs results	☐	☐
X-ray, CT Scans, MRI or other radiological results	☐	☐

No Authorization

☐ Please initial of you **do not authorize** any messages related to my healthcare to be left in my HOME/CELL/WORK phone /answering machine.

Assignment of Benefits

All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arraingments have been made in advance. I hereby authorize **Central Nebraska Neurology** to furnish information to insurance carriers and other physicians and hospitals concerning my illness and treatments and hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature _____ **Date** _____

Telehealth Consent

I consent to Telehealth/Telemedicine care performed by my physician and all others associated health care providers at **Central Nebraska Neurology**. I acknowledge that I have been given the Telemedicine/ Telehealth Policy or can request it at any time. **Signature** _____ **DATE:**_____