Minneapolis Clinic of Neurology **Patient Authorization and Consent Form** **Acct#_____**

Consent for Treatment: I consent to and authorize my health care provider to examine and treat me. I understand this could include lab tests or other diagnostic procedures and, education or video/photographs. I understand my provider is available to explain the purpose of the procedure(s) and treatment(s), and I have the right to refuse such procedure(s) or treatment(s).

- I authorize Minneapolis Clinic of Neurology to verbally communicate regarding my personal health care or billing information with me by leaving voicemail messages on phone number: _____.

Privacy: I acknowledge I have received a copy or have been made aware of Minneapolis Clinic of Neurology's privacy practices. I understand I may request a copy of this privacy notice if I so desire. Minneapolis Clinic of Neurology providers or staff may discuss and disclose health care or billing information to other individuals as I deem authorized to consent via verbally or by utilization of MyHealthRecord.com as follows:

Name: _____ ___ Relationship: _____ Phone #: _____

Name: _____ ___ Relationship: _____ Phone #: _____

Assignment of Benefits and Release of Information: I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or operated by Minneapolis Clinic of Neurology (MCN), including physician services, or by any provider under contract with MCN or participating in a provider network in which MCN or its affiliates participate. I consent to MCN releasing my health records and other information related to my health care services for payment and healthcare operations purposes. I agree that MCN may release my health records and other information to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties.

Release of Information by Payers and Networks: I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from MCN or any other provider, with MCN, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

Release of Information to Health Care Providers: I consent to the release of my health records created, received and maintained by MCN for my treatment to other health care providers who are involved in my treatment.

Release of Medical Records for Research: Medical or scientific researching may request a copy of our patient records in order to conduct a research study. Researchers cannot use patient names or other identifying characteristics when reporting results for their research. I authorize MCN to use or disclose my medical records for research, including health records created by MCN and those records MCN receives from other health care providers while treating me.

Payment Agreement: I understand that I am financially responsible and agree to pay promptly for any charges for the care and treatment rendered to me or my dependent(s) not covered by my insurance plan or if I do not have active insurance coverage. Any balance due after 30 days will be subject to a finance charge of 0.666% per month (8% annual percentage rate). Receiving cancellation information in advance allows us to schedule and serve other patients. We reserve the right to bill you $50 for missed appointments without a 24-hour advance notice. Please contact us on Friday for Monday appointments. This fee is not covered by your insurance carrier, nor Medicare, and will be your responsibility to pay before your next visit.

You may withdraw this consent at any time by advising us in writing at: Minneapolis Clinic of Neurology, 4225 Golden Valley Road, Golden Valley, MN 55422. I understand my revocation shall have no effect on releases that have already been made.

Signature of Patient or Personal Representative	Print Patient's Name	Date of Birth	Today's Date
Relationship to Patient (if patient is unable to sign)	Reason Patient Unable to Sign		