Blue Sky Neurology

Consent, Payment Policy and Payment Agreement

A. CONSENT TO MEDICAL CARE AND TREATMENT.

I,_____, the undersigned, hereby consent to the following treatment:

1. Administration and performance of all medical care, diagnostic procedures and treatment;
2. Use of prescribed medications;
3. Administration of any needed anesthetics;
4. Performance of such procedures or treatments that are deemed necessary or advisable in my medical care and treatment;
5. Performance of diagnostic procedures, tests and cultures; and
6. Performance of other medical care, diagnostic tests, procedures and services deemed medically necessary or advisable by my physician or his/her assigned designees.

I fully understand and agree that this consent is provided voluntarily and in advance of any specific diagnosis, procedure or treatment and that I have the right to refuse these services. I intend this consent to be continuing even after a specific diagnosis is made and/or treatment is recommended. This consent shall remain in full force and effect until revoked by me in writing and will not affect any actions taken prior to my written revocation. I understand and agree that this consent applies at all CarePoint, P.C./Blue Sky Neurology office locations.

B. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

I understand and agree that CarePoint, P.C./Blue Sky Neurology will use and disclose my protected health information for purposes of treatment, payment, continuity of care and health care operation purposes and that I have certain rights with respect to my protected health information, as described in the Notice of Privacy Practices, the receipt of which is hereby acknowledged. You may be contacted using any and all communication mechanisms you provide (e.g. telephone, email, mail, etc.).

I understand that CarePoint, P.C./Blue Sky Neurology will maintain my medical record and protected health information for a period of ten (10) years after my last date of treatment. I understand and agree that it is my responsibility to request a copy of my medical record prior to the date of destruction and that I will not receive notification prior to the destruction of my medical record and protected health information.

C. FINANCIAL POLICIES AND PAYMENT AGREEMENT.

I hereby acknowledge and agree that I am voluntarily seeking health care services from Blue Sky Neurology, a Division of CarePoint, P.C. ("Blue Sky Neurology") and its providers. I understand and agree that payment for the services I receive is my responsibility. I understand and agree that Blue Sky Neurology may bill my insurance/third party payor as a courtesy, but is not obligated to do so.

I acknowledge, understand and agree that it is my sole responsibility to determine what my health insurance covers, whether the health care provider I am seeing is a participating provider under my health insurance and whether my health insurance covers the health care services I receive from or through Blue Sky Neurology I understand and agree that I am solely responsible for payment of my entire account balance.

I understand and acknowledge that Blue Sky Neurology does not participate in all insurance plans and that Blue Sky Neurology is not responsible for obtaining referrals, approvals or authorizations, or for knowing the requirements of my health insurance plan. I acknowledge and agree that it is my sole responsibility to know, understand and comply with the requirements of my health insurance plan.

Consent, Payment Policy and Payment Agreement (Continued)

I understand and agree that it is my responsibility to provide Blue Sky Neurology with appropriate and current insurance information and to notify Blue Sky Neurology immediately upon any change in my insurance coverage. I understand that my insurance company(ies) may deny payment of claims for the health care services rendered to me, and I understand that I may be fully responsible for my entire account balance.

I understand that I will be responsible for paying co-payments, deductible, non-covered services and all charges for health care services rendered that are not covered by my insurance company(ies) in whole or in part. I understand that all co-payments are due at the time of service. I agree to pay all required co-payments, deductibles and charges for non-covered healthcare services.

I understand that Blue Sky Neurology may charge me fees for cancellations with less than 24 hours' notice for an office appointment and less than 48 hours for a procedure appointment, and for failure to show up for an appointment, the completion of letters and various types of paperwork and forms Blue Sky Neurology completes on my behalf, returned checks and other miscellaneous fees. I understand and agree that all fees are due when assessed and must be paid before another appointment will be scheduled. I also understand and agree that a second no show or a second cancellation with less than the required minimum notice may be grounds for discharge from Blue Sky Neurology's practice.

In the event of failure to pay for medical services rendered or fees assessed, I understand that I may be discharged from the services of Blue Sky Neurology. Additionally, I understand that I may be referred to a collections agency for non-payment of amounts due for services rendered by Blue Sky Neurology or fees assessed. I understand that I will be responsible for a collection fee and all agency and attorney fees and costs associated with the collection process (such as court costs), and that these fees and costs will be added to my account balance.

I hereby understand and agree that a photocopy, scanned or electronic of this Consent, Payment Policy and Payment Agreement shall be valid as the original. I hereby consent to medical care and treatment as stated above. I also hereby agree to the financial policies and requirements of Blue Sky Neurology and to the payment agreements stated in this Consent, Payment Policy and Payment Agreement.

Patient or Responsible Party Signature: _____

Date: _____

Relationship if signed by a responsible party other than the Patient: _____