Orlando Epilepsy Center

# Consent for Treatment

(THIS DOCUMENT EXPIRES 3-YEARS FROM DATE SIGNED)

**TO THE PATIENT - Consent for Care and Treatment Consent:** *You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner), and other health care providers or the designees as deemed necessary, to perform a reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). Waiver of Jury Trial; each party hereby irrevocably waives its right to trial by jury in any action or proceeding arising out of this agreement or the transactions relating to its subject matter.

**I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.**

| | |
|---|---|
| ______________________________ | ______________________________ |
| Signature of Patient or Personal Representative | Date |
| ______________________________ | ______________________________ |
| Printed Name of Patient or Personal Representative | Relationship to Patient |
| ______________________________ | ______________________________ |
| Name of Witness Employee | Job Title |
| ______________________________ | ______________________________ |
| Signature of Witness | Date |

Orlando Epilepsy Center

# Patient Financial Policy Agreement

Thank you for choosing Orlando Epilepsy Center (OEC) as your healthcare provider. We are committed to your treatment being successful and we appreciate your trust in us. The following statement of our Financial Policy, which you are required to read, agree, and sign prior to your treatment being rendered.

- **Self-Pay Patients**: Payments in full is due at the time of service.
- **Patients with Insurance**: We will file your insurance claim for you. However, to work with your company, we must have complete and current information, a copy of your insurance card and your signature on file.
- **Insurance:** By signing below, you authorize OEC to bill your insurance carrier. It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions that you may have regarding coverage of specialty services.
- **Co-Payments, Co-insurances and Deductibles**: All patient balances are due at the time of service. We accept cash, check, credit cards (Visa, MasterCard, American Express, Discover, and Care Credit).
- **Non-Covered Charges:** Please understand there may be some charges for our services which you insurance company considers *non-covered* and may be excluded from your policy. Accordingly, you will be responsible for these charges.
- **Denied Claims:** Failure to present your current insurance information before services being rendered may result in denial of your claim and subsequent billing for unpaid services.
  - You are responsible for any charges that are denied by your insurance company.
- **Medicare**: We are participating Medicare provider. We will bill Medicare, for you, as well as any secondary insurance that you may have. However, that does not mean that all services are covered. Additionally, you are responsible for any co-payments, usually 20% of the allowed amount, as well as any unmet annual deductible. Medicare may allow a service but your secondary insurance provider may not; therefore, you will be responsible for that portion of the bill.
- **Request for Medical Records**: Please allow 7 to 10 business days for processing of all medical records request. Patient must complete ***Records Release Authorization*** form for each request.
- **Returned Checks**: Any returned check is subject to a $25.00 bank fee.
- **Special Financial Arrangements**: We offer monthly payment plans with balances to be paid off in **four** consecutive payments. We also offer financial hardship discounts, but this requires the patient to complete a *Financial Evaluation Form* with proper supporting documentation (to include patient income).
- **Past Due Accounts**: All past due accounts are subject to collection proceedings. All fees, including, but not limited to the maximum interest that is allowable by law, a 35% collection agency fee and awarded court fees will become your responsibility in addition to the patient balance should you placed with an external collection agency.
- **FMLA/Disability/DMV Forms:** There is a $35.00 for the completion of forms requested by patients.

*I authorize release of any medical information necessary to process this claim. I authorize payment of medical benefits to Orlando Epilepsy Center.*

**I have read, understand, and agree to the above Financial Policy.**

_______________________________________ _______________________________________

Signature of Patient or Financially Responsible Person Date

_______________________________________

Print Name

Orlando Epilepsy Center

# Notice of Privacy Practices, Acknowledgement, and Consent

(Consent to use PHI)

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Orlando Epilepsy Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

☐ I have received a copy of the Notice of Patient Privacy Policy.

☐ Orlando Epilepsy Center may share information with the following family member:

Family Member Name: _______________________________________ Phone: _______________________________

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will not be in violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**By my signature, I give permission to leave a message on my answering machine and/or cell phone.**

Cell Phone #: ________________________________

**By my signature below, I give my permission to use and disclose my health information.**

____________________________________________ ______________________________________

Patient or Legally Authorized Individual Signature Date

____________________________________________ ______________________________________

Print Patient's Full Name Time

____________________________________________ ______________________________________

Witness Signature Date