Port City Neurosurgery & Spine

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PATIENT CONSENT FORM

I authorize Port City Neurosurgery & Spine, P.C. to release any medical information acquired in the course of m examination or treatment and authorize payment of medical and/or surgical benefits directly to the provider named. Port City Neurosurgery & Spine may file insurance appeals on my behalf. I also give Port City Neurosurgery & Spine permission to obtain any medical information needed from other sources in the course of patient's treatment or examination.

I understand that regardless of any insurance that may be filed on my behalf, I am ultimately responsible for my own bills. It is agreed that in the event the services of an attorney or collection agency are required to collect any outstanding balance owed to Port City Neurosurgery & Spine, P.C. the cost of reasonable attorney's fees will be added to the outstanding balance. Any outstanding balances on my account over 45 days old may be subject to a 1½ % per month (18% annual) finance charge. Patient and/or Legal Guardian signing below agree to be liable for the payment of the medical services provided for the patient named below.

I also understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers, including filing insurance appeals on my behalf, if necessary.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (please print) ____

Date of Birth:______________________ Date: ___________________________

Signature: ____

Relationship to Patient: ____