AUTHORIZATION/ACKNOWLEDGEMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, (Print Patients Name)_____have read a copy of Advanced Neurology's Notice of Privacy Practices.

_____ _____

Patient Signature (or Guardian) Date

CANCELLATION POLICY:

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24hrs of the scheduled appointment. Advanced Neurology reserves the right to charge the patient a $50 fee if the patient does not cancel the appointment within 24hrs. Additionally, Advanced Neurology reserves the right to reschedule appointments to which the patient is more than 30 minutes late.

_____ _____

Patient Signature (or Guardian) Date

CONTACT PERMISSION:

In the event that Advanced Neurology needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

CHECK ALL THAT APPLY:

O Alternative phone number to contact you _____

O Leave a message on an answering machine.

O Speak with spouse/ significant other/ Emergency contact/ other family member

Name_____

O Do NOT contact anyone else on my behalf or leave message on machine

_____ _____

Patient Signature (or Guardian) Date