AUTHORIZATION/ ACKNOWLEDGEMENT

RECEPT OF NOTICE OF PRIVACY PRCTICES:

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 can not adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel/ reschedule within 24 hours of the scheduled appointment. Advanced Neurology reserves the right to charge the patient a fee if the patient does not cancel the appointment within 24 hours. Additionally, Advanced Neurology reserves the right to reschedule appointments to which the patient is more than 15 minutes late.

_____

Patient signature (or Guardian) Date

CONTACT PERMISSION:

In the event 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:

- Alternative phone number to contact you _____
- Leave a message on a answering machine.
- Speak with spouse/ significant other/ Emergency contact/ Other family member.

  Name _____

- Do **NOT** contact anyone else on my behalf or leave a message on machine.

_____

Patient signature (or Guardian) Date