Jefferson Neurology LLC
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POLICIES, CONSENT AND AUTHORIZATION INFORMATION.

OFFICE POLICIES

Appointments: There are sometimes unpredictable last minute schedule changes. We recognize that emergencies do happen, so if you must cancel your appointment, please notify our office 24 hours before your scheduled appointment time or a 'no show' fee of $50 will be assessed. We may not make confirmation calls prior to your appointment. Please mark your calendars accordingly.

Living situation: Please notify us of any changes in your living arrangement, including: address, phone number, marital status, legal status, employment and major illnesses.

Tests: Commonly ordered tests through our office are MRI, CT, EEG, 2D Echo, Ultrasound, Blood and Urine tests amongst others. We routinely do not make appointments for these tests. The testing facility will contact you directly to schedule. Certain tests will require authorization through your insurance carrier. Delays may occur in the authorization process. We request that you call us in a week if the testing facility has not contacted you. The turnaround time for results of the tests vary. Multiple tests may be ordered at the same time. Many of these tests may take 2-3 weeks for the reports to be available. We request that you wait 2 weeks for us to contact you.

Follow-up appointments: You will be called about the results of the tests. We prefer that follow-up appointments are made to review test results, if necessary. The results may take 2-3 weeks to reach us. If you have been asked to schedule a follow-up, please call a few weeks in advance.

Referrals: If you have been referred to another specialist, your information will be faxed to them. Their contact information will be provided to you. Please contact their office if you have not heard from them in a week.

Prescriptions: Medication refills will be addressed at each visit. In the event that you need a prescription refill and do not have an upcoming appointment, you may contact your pharmacy. If there are no refills remaining, either you or your pharmacy should contact us.

Medication: Medications will be electronically sent to your pharmacy. Certain prescriptions may need an actual paper prescription to be submitted to the pharmacy. You will be informed of that.

Medication samples: Pharmaceutical companies provide us samples for certain medications for you to 'try before you buy'. Generic medication samples are usually not provided.

Medications (Generic versus Brand name): Certain insurance carriers require that generic medications are used whenever possible. Generic medications are also commonly less expensive. If you or your insurance carrier have a preference for generic medications, please inform us in advance.

Medication denial: Your insurance provider may deny certain medications. It may need to be prior-authorized. Your insurer has a list of medications that they consider as first line, which are less expensive to provide to you. As there are multiple insurance carriers, we are unable to recognize beforehand whether a medication will be covered by your insurance. The pharmacy will process your prescription and make that determination. If denied, there are two routes to proceed. Firstly, you may contact your insurance carrier directly to question and contest the reason for denial. They may have a form for us to fill and send to them, which we will facilitate. We commonly find that such decisions are upheld in-spite of appeals. As you are the responsible beneficiary, we may request that you communicate with your insurance to understand and contest their decision. Alternatively, you may contact your insurance or have your insurance contact us, to provide us with a list of what they would consider as appropriate alternatives.

Medication Refill: Medication refills are done by batches twice a week. Please make sure you contact your pharmacy for refills at least three days in advance. If you run out of refills, your pharmacy will contact us.

INSURANCE AUTHORIZATION & ASSIGNMENT

I request that payment of authorized insurance benefits be made to Jefferson Neurology LLC for any services furnished to me by Zakir Ali, M.D.. I authorize any holder of medical information about me to release to my insurance carrier and/or its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made to Jefferson Neurology LLC and authorizes release of medical information necessary to pay the claim. If Item 12 of 14 of the HCFA-1500 claim form is completed; my signature also authorizes releasing the information to the insurer or the agency shown.

FINANCIAL POLICIES

Fees: A list of services we offer and fees are available by contacting our billing office.

Insurance: As a courtesy to you (our patients), we bill all primary insurance. It is your responsibility to pay any deductible amount, co-insurance or other balance unpaid by your insurance company.

Billing: To help cover the cost of billing we charge interest at 1.75 percent per month on all outstanding balances over 90 days. If you wish to avoid these charges, please pay in full at the time services are rendered.

Oregon Health Plan Patients: Our office requires that you provide us with a current recipient card each month. Patients who do not have this card with them at each visit might be denied services.

Motor Vehicle Insurance: As a courtesy, we will bill your Motor Vehicle Insurance. We request a copy of your private insurance information in the event that you claim is closed or your PIP (personal injury protection) has run out.

Worker's Compensation: If you are seeing us due to a work related injury, we will bill your Worker's Comp insurance. If you were injured at work but do not have a claim opened, please let our staff know immediately so we can make the proper arrangements. We will request a copy of your private insurance information in the event that your claim is closed or the provider treats you for something that is not included in your claim.

Notice of Privacy Practices: You have the right to receive a written description of our Notice of Privacy Practices. It describes the uses and disclosures of health information made, the information practices followed by our employees and health care providers, and your rights regarding your health information. A copy of the Notice of Privacy Practices is available upon request.

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Jefferson Neurology LLC to use and disclose the health and medical information for the purpose of Treatment, Payment and Health Care Operations.

Treatment includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any health care professionals that cover our practice by telephone as the on-call provider. We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification, and pre-authorization.

Health Care Operations includes the necessary administrative and business functions of our office.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Jefferson Neurology LLC has already used or disclosed the information in reliance on this CONSENT.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, correcting or amending that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information and complaining if you think that your rights have been violated. We have available a detailed Notice of Privacy Practices which you have a right to obtain by upon request.

I have reviewed, agree and consent to the sections relating to policies, consent and authorization that have been provided to me.

Name Signature Date

(Version 1.4)