COMPREHENSIVE NEUROLOGY SPECIALISTS

Dr Ishaq Ali MD

Comprehensive Neurology Specialists, PLLC

CONSENT TO TREAT RELEASE OF MEDICAL INFORMATION

FINANCIAL RESPONSIBILITY

CONSENT TO TREATMENT: I voluntarily consent to receive medical and healthcare services provided by the Comprehensive Neurology Specialists, PLLC (CNSPLLC), physician assistants, nurses, technicians, and other CNSPLLC employees, as my physician deems reasonably necessary. I understand that this general consent applies to examinations, testing, procedures, and treatment. I am aware that the practice of medicine is not an exact science and I further acknowledge that no guarantee has been or can be made as to the results of the treatments or examinations at CNSPLLC.

This general consent to treatment will be valid and remain in effect as long as I am a patient at CNSPLLC, unless I revoke this consent, in writing.

RELEASE OF MEDICAL INFORMATION: Your protected health information pertains to your diagnosis, treatment and billing information obtained by CNSPLLC. Our Notice of Privacy Practices provides information about how CNSPLLC may use and disclose your protected health information for your treatment, for your health insurance and as permitted by law. CNSPLLC staff will provide you a copy of our Notice of Privacy Practices. You may ask to view that notice at any time.

FINANCIAL RESPONSIBILITY: In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to CNSPLLC.

I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third- party payer, up to the total amount of my medical and health care charges, to CNSPLLC. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by CNSPLLC, to CNSPLLC.

_____	_____	_____
Patient/Legal Guardian Signature	**Date**	**Time**
_____	_____	
Patient Printed Name	**Patient Date of Birth**	

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