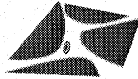


Neurology P.A.

Liliana Montoya, MD

American Board of Psychiatry & Neurology Certified

George Li, MD

Diplomate, American Board of Psychiatry & Neurology Certified

Diplomate, American Board of Electrodiagnostic Medicine Certified

Authorization and Assignment: I assign payment to Neurology, P.A. for any medical benefits due to me for rendered services.

Payment Agreement: Payment for a non-covered service, deductible and co-pay is expected at the time of service. If payment is made by check or like instrument drawn on a bank or other depository institute and such instrument is returned as non-sufficient funds, a $50.00 returned check fee will be added onto the appropriate account. **Should your account be sent to a Collection Agency, a fee of 30% may be added to your bill to cover the Agency fee. There will be a 50.00 fee for any missed appointments, and 100.00 fee for procedures if we do not receive 24 hour notice given to an employee! Answering service is not acceptable!** We further more reserve the right to stop making any more appointments until the outstanding debt is paid in full and your risk of Discharge from our practice is not taken care of.

Release of Medical Records: I authorize the release of medical or other information that may be necessary to request claim reimbursement from my insurance carrier(s). Neurology, P.A. is also authorized to release to the Centers for Medicare and Medicaid Services (CMS) and its agents. Any information needed to determine benefits for related services.

Medicare Authorization: I request that payment of authorized Medicare benefits be made on my behalf to Neurology, P.A. for any service furnished to me at or billed through Neurology, P.A.

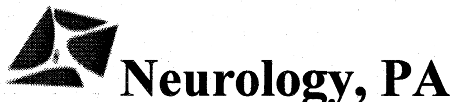
Medigap Authorization: Medigap is a privately offered Medicare supplemental health insurance plan. In the event that I have a Medigap Medicare supplemental plan, I request that payment of authorized Medigap benefits be made on my behalf to Neurology, P.A. for rendered services. I authorize any holder of medical information about me to release to my Medigap insured any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment to cross over automatically. This assignment will remain in effect until revoked by me in writing.

A photocopy of this assignment is to be considered as valid as the original.

I have read the above information and understand it.

______________________________	______________________
Guarantor's signature	Date
______________________________	______________________
Witness	Date

4161 Tamiami Tr., Suite 201, Port Charlotte, FL 33952 Telephone (941) 764-0800 Fax (941) 764-6494



Neurology, PA

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully. At Neurology, PA, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment.

* For example, a review of your file by a specialist doctor whom we may involve in your care.

* We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

* We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

* We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

* We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

* In an emergency, we may disclose your health information to a family member or another person responsible for your care.

* We will need to release some or all of your health information, when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

* You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.
* You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
* You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method you prefer. You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs. You have the right to receive a report of who we disclose your information to.
* You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
* If our privacy and security measures or systems are breached in any way, we will notify you.
* You have the right to receive a copy of this notice.
* If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.
Please contact our Office Manager, at (941) 764-0800 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment:

Signed ______________________________ Date ______________

If signing as a parent or guardian, please note the name of the patient ______________________