Southlake Neurology and Neurophysiology Clinic, PLLC

Consent for Medical Treatment

After filling it out in writing or on Internet please print and sign before your appointment

I hereby give permission to **Southlake Neurology and Neurophysiology Clinic, PLLC** its physicians and employees for medical treatment for myself or for the patient (if I am the patient's representative, e.g. parent, guardian, or medical power of attorney). I understand that this will involve taking a medical history, performing a physical examination, possibly removing articles of clothing for the examination, forming a clinical impression, making a treatment plan, ordering or performing diagnostic studies, communicating with other persons involved in the medical care, prescribing medications, and ordering medical treatments.

Patient's signature_____ Date_____

Patient's last name Middle Initial First Name

Representative's signature_____ Date_____

Representative's last name Middle Initial First Name

Authority of representative:

Acknowledgment of Notice of Privacy Practices

Federal law requires us to ask you to sign this statement to confirm that we provided you with our Notice of Privacy Practices.

Southlake Neurology and Neurophysiology Clinic, PLLC has provided its Notice of Privacy Practices to me.

Patient's signature_____ Date_____

Patient's last name Middle Initial First Name

Representative's signature_____ Date_____

Representative's last name Middle Initial First Name

Authority of representative:

Assignment of Benefits

I hereby assign Medicare, Medicaid, and insurance benefits to **Southlake Neurology and Neurophysiology Clinic, PLLC.** In the event where the insurance does not pay the amount billed or there is balance on my account, I will be financially responsible for this amount or any other outstanding balance.

Signature_____ Date_____