CENTRAL FLORIDA NEUROSURGERY INSTITUTE
PATIENT POLICIES AND NOTICES.

PATIENT COPY

Please note by signing Central Florida Neurosurgery Institute's Patient Registration Forms you have attested that you received the policies listed below and are aware of the implications. Please take a moment to familiarize yourself with our office policies. Thank you!

1. FORM COMPLETION POLICY - Central Florida Neurosurgery Institute charges for form completion after the first courtesy form. The first requested form from each patient will continue to be completed at no charge. We will continue to help our patients to the best of our ability but have found the need to charge for completion of additional forms. Each additional form will be completed at a charge of $25.00 per form. This charge will be payable by the patient requesting completion and will not be billed to insurance companies, etc. Requests will be completed in seven to ten business days and payment is due prior to or upon completion of the form.

2. MEDICATION REFILL POLICY - There is a twenty-four hour to forty eight hour (2 business days) turn-around time for medication refill request. We will do our best to process requests in a timely fashion, the same day if possible. The preferred methods to initiate a refill request are:

a. Request your prescriptions at the time of your schedule appointment.
b. Call your pharmacy and have the pharmacy fax a written request to # 407-288-8639.

If this is not possible, you may call in the request. However, if you wait to call in a refill request after 4pm or on a Friday afternoon then your request may not be addressed until the next business day.

Please be proactive in your care and make prescription refill requests before you are out of your medication. Do not wait until you are completely out of medication to call in a request.

3. MEDICAL RECORDS RELEASE POLICY - You will need to sign a release form in order for our office to release any records to the doctor(s) of your choice. If your attorney(s) are requesting records then they must submit a signed records release to our office with your signature. Please allow one to two weeks for request to be processed.

If you as the patient are requesting a copy of your records, please be informed that the cost is $1.00 per page. Please allow up to one week for your request to be processed.

4. PRESCRIPTION HISTORY SIGNATURE CONSENT POLICY - If you sign the consent of External prescription history on the CFNI registration forms, you authorize our office and its affiliated providers to view your external prescription and pharmacy history via Rxhub and the Sure scripts service.

4. APPOINTMENT NO SHOW / LATE CANCELLATION POLICY
If it is necessary to cancel/reschedule your appointment, please do so 24 hours PRIOR to the time of your scheduled appointment. If you do not cancel an appointment or no show, you will be responsible for a $25.00 charge. The fee of $25.00 is to be paid by the patient and is not billable to any insurance or third party payers.

PATIENT COPY

LEGAL ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL/PLAN DOCUMENTS:

LEGAL ASSIGNMENT OF BENEFITS & RELEASE
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

In consideration of the amount of medical expenses to be incurred, I, who have signed consent to legal assignment on my Patient Registration Form, have insurance and/or employee health care benefits coverage with the previously identified company, and hereby assign and convey directly to Central Florida Neurosurgery Institute all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. By signing the assignment and consent on the Patient Registration Form, I authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of the signature on the Patient Registration Form for the insurance and/or employee health benefits claim submissions related to care rendered to me by this office.

I hereby convey to Central Florida Neurosurgery Institute the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor's expense.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of the Patient Registration Form signed assignment is to be considered as valid as the original. I have read and fully understand this agreement.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Central Florida Neurosurgery Institute would like to ensure you are aware of its Notice of Privacy Practices ("Notice"). Your acknowledgement or lack of acknowledgement of this Notice will not affect your medical benefits. You will continue to receive the same service as usual. **Please note by signing Central Florida Neurosurgery's Patient Registration Form you have attested that you received the Notice**.

Please note that this acknowledgement applies only to you. Other members of your family who are on your medical benefits plan should make a separate acknowledgement that they have read the Notice of Privacy Practices IF THEY ARE a PATIENT OF THIS OFFICE.

PLEASE NOTE A COPY OF THE NOTICE OF PRIVACY PRACTICES IS POSTED IN OUR OFFICE AND ON THE COMPANY WEBSITE, WWW.CFNEURO.COM FOR YOUR CONVENIENCE. PLEASE ALERT OFFICE STAFF, IF YOU WOULD LIKE A PERSONAL COPY.

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by Central Florida Neurosurgery Institute (from here forth referred to as "the Practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised Notice at our office or via our website at www.cfneuro.com

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restrictions(s), such restrictions are then binding on the Practice.

CENTRAL FLORIDA NEUROSURGERY INSTITUTE
AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: **(PLEASE LIST NAMES OF AUTHORIZED PERSON(S) AND DESCRIPTION IN SPACE BELOW)**

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

I agree that the Practice may also disclose the following types of information contained in my medical record (**please initial next to the categories you authorize this office to include in any disclosures**): If none apply, leave blank.

____ HIV/AIDS Information ____ Mental Health Information ____ Substance Abuse Information

____ Sexually Transmitted Disease ____ Pregnancy Information (If patient is under 18 years of age)

I consent to the Practice releasing information to me in the following manner(s) (**please initial category of choice listed below**):

____ Via email to the Patient's designated e-mail address which is: (I am responsible for notifying the practice of any changes to my e-mail address.) _____

____ Via standard US mail with any envelopes being marked personal/confidential and addressed to me.

____ Via telephone, if I contact the Practice and provide the appropriate information (including name, social security number and unique personal identifier).

____ Via fax to my designated fax number which is _____.

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I am the patient or the authorized party to act on the behalf of the patient, to sign this document verifying consent to the above terms.

Date: _____

_____ _____

Signature of Patient or authorized representative' Please Print Name

_____ _____

Authorized representatives' relationship to Patient Description of Authority to act on patient's behalf.