MILLMAN NEUROLOGY

GENERAL CONSENT

Consent for Medical Treatment:

I hereby consent to Alan Millman, MD, PLLC (DBA "Millman Neurology"), including all of its clinical staff ("Millman Neurology") providing and performing such medical care, tests, procedures, and other services deemed necessary or beneficial for my health and wellbeing. I understand that to ensure quality and continuity of care, all Millman Neurology providers and staff may have access to my electronic health record and will access same as necessary for my medical care.

Consent for Communication

I understand that brief messages may be left on my voicemail or with anyone who answers my phone unless I provide the practice with alternative instructions for communication. I understand that it is my responsibility to access these communications.

I understand that brief text messages may be sent to the mobile phone number I have provided. These messages will not include protected health information. I understand that I may be responsible for additional fees charged by my phone service provider. I can opt-out of these text messages at any time by informing the office.

I understand that it my responsibility to Inform the office of any changes to my primary phone number, address, or email as soon as possible.

Assignment of Insurance Benefits

I authorize payment to Millman Neurology of all monies and/or benefits to which I may be entitled from government programs, insurance carriers, or others who are financially responsible for the cost of my medical care and treatment. I hereby authorize the release of any and all medical records pertaining to me for the purposes of payment for the services rendered to me.

Acknowledgement of Financial Responsibility

I agree to pay all amounts for which I am responsible as a result of the services rendered to me.

I understand that I am responsible for my health insurance co-payment, and it must be paid at the time of service.

I understand that I am financially responsible for my health insurance deductible, coinsurance, and non- covered service.

I understand that if my plan requires a referral, it is my responsibility to obtain it prior to my visit.

I understand that I am responsible for all charges incurred that my insurance will not cover. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

I further understand that in the event I request that a visit not be billed to my health insurance carrier, I will be financially responsible for that visit, and I must make payment in full.

If I do not have active insurance coverage, I agree to pay for the medical services rendered to me at the time of service. I understand that I am entitled to receive an estimate of how much the visit will cost, and that the actual cost may differ from the estimate.

I understand that if I have a commercial insurance, that Millman Neurology and/or Dr. Alan Millman does not have a contract with, then I will be responsible for all charges incurred that are not covered by my insurance company.

I hereby authorize Millman Neurology and Dr. Alan Millman to release any information acquired in the course of my examination and treatment to my insurance company for coverage of my review and/or claims processing.

I hereby authorize my insurance company to pay the benefits due me directly to Alan Millman, MD, PLLC (DBA "Millman Neurology") or to Dr. Alan Millman.

I understand that it is my responsibility to notify this office of changes to my name, address, insurance, employer and insurance card(s).

I understand that it is my responsibility to inform Millman Neurology if this visit is for Worker's Compensation or No Fault/Auto Insurance.

I understand and agree that a third party billing company may bill and/or collect payment on behalf of Millman Neurology.

If a patient chooses not to sign the provided practice consents and/or the office policies, then patient will not be accepted into the practice, and no doctor-patient relationship will be established.

By signing below, I acknowledge that I reviewed this form, understand its contents, and agree to abide by these policies.

X_____ _____

Patient Signature Today's Date

_____ _____

Print Name Date of Birth

_____ _____

Signature of patient representative Relationship to patient

MILLMAN NEUROLOGY

OFFICE POLICIES

Referrals

Depending on the insurance plan, insurance companies may require a referral to be obtained by the patient and sent to our office prior to the visit.
The patient is responsible for contacting their primary doctor's office to have this sent. The patient should then contact our office prior to the appointment, to ensure that this has been received.
The patient cannot be seen if this referral has not been received prior to the scheduled appointment time.

Payments

We will collect patient balance at each visit. Patients cannot be seen if there is any unpaid balance on their account.
We only accept Credit Cards/Apple Pay/Google Pay at the front desk.
We do not accept cash or cheques in the office.

Billing Questions

If you have any questions regarding your bill, first contact your insurance carrier.
Then, if there are any further questions regarding charges, balances, late fees, collections, etc., you may contact our third party billing agency.

Prescriptions

- When a prescription is provided in the office, an adequate number of refills are included until the next scheduled followup visit. The patient should make an appointment in the office before they run out of the last refill.
- If there are no more refills, then the patient needs to be seen in the office for followup and consideration of renewal of the medication.
- ***Contact your PHARMACY for refill requests.***
- The pharmacy will then send us an electronic request. If the refill is electronically approved by the doctor, then the pharmacy will contact the patient when it is ready for pickup.
- If the refill is denied, then the patient needs to be seen in the office for followup and consideration of renewal of the medication.
- Allow 2 business days for refills.
- 90 day supplies will be provided once the patient is on a stable dose of medication. 90 day supplies will not be provided during the initial/trial phase of a medication, or if dosage is being adjusted.
- If the insurance carrier requires pre-authorization, then the medication may be delayed.
- If the insurance carrier does not cover a medication, then the patient should contact the insurance carrier for their alternative equivalent medication and inform our office. A new prescription will then be sent to the pharmacy.
- Controlled substances of any kind will not be authorized after office hours.

Tests and Pre-authorizations

Some tests/procedures may require pre-authorization from the insurance carrier. This only gives permission for the test/procedure to be performed. It is not a guarantee that the insurance company will pay for the test/procedure. The patient may still be responsible for the full cost.
It is the patient's responsibility to check with the testing facility and/or insurance carrier regarding the pre- authorization status. This process may take 10 or more business days.

Letter/Form Completion (disability, work related, etc)

Allow 10 business days for the letter/form to be completed, there is a $45.00 charge for this service, which is subject to change.
This fee does not ensure that the patient will obtain their desired outcome. These documents are based solely on professional medical opinion, and disability is not determined by the physician. Determination of disability is between the patient and their human resources department or other agency.

After Hours/Emergencies

- ***For any emergencies DO NOT call our office. This will delay care. Call 911 immediately.***
- Messages left on office voicemail will be returned that day or the next business day. If for some reason, no callback is received by the next afternoon, then please call again.

- Our office hours are subject to change. Please contact our office for our most up-to-date hours.

Discharge from Practice:

- A patient may be discharged from the practice for breakdown in the doctor-patient relationship, noncompliance, or other reasons.
- We reserve the right to discharge a patient from the practice for disrespectful behavior towards our staff, other patients, and/or the physician.
- If there are three or more instances of no-shows or late cancellations in a twelve month period, then the patient may be discharged from the practice.
- Any unpaid balance after 3 months may be referred to a third party collections agency. This may adversely the patient's credit rating. Patient may be discharged from the practice for lack of financial responsibility.
- If a patient is discharged, then the patient should contact their pcp or insurance carrier for another neurology provider. A 30 day supply of previously prescribed medication will be provided if needed. Any other emergent care can be handled via PCP or an urgent care center/hospital.

If a patient chooses not to sign the provided practice consents and/or the office policies, then patient will not be accepted into the practice, and no doctor-patient relationship will be established.

This Office Policy is valid as of May 29, 2022, and supercedes any prior policies. Any updates to the policy will be provided at next patient visit.

By signing below, I acknowledge that I reviewed this form, understand its contents, and agree to abide by these policies.

X_____ _____

Patient Signature Today's Date

_____ _____

Print Name Date of Birth

_____ _____

Signature of patient representative Relationship to patient

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the Millman Neurology Notice of Privacy Practices.

X_____ _____

Patient Signature Today's Date

_____ _____

Print Name Date of Birth

_____ _____

Signature of patient representative Relationship to patient