

ADVANCED NEUROLOGIC ASSOCIATES, INC.

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Fax (419) 483-8418

William Bauer, MD ~ Brendan Bauer, MD ~ Steven Benedict, MD
Iman Abou-Chakra, MD ~ Nicole Danner, DO ~ Michael Leslie, MD

Patient Name: _____

AUTHORIZATION AND RELEASE: I hereby authorize the healthcare providers of *Advanced Neurologic Associates, Inc.*, to examine and treat me or my dependent listed above. Advanced Neurologic Associates, Inc. may release any pertinent information necessary for reimbursement to my insurance carrier. I also authorize benefits to be paid directly to *Advanced Neurologic Associates, Inc.* and acknowledge that I am ultimately responsible for all charges that my insurance does not cover. It is my responsibility to pay any deductible amount, co-payment or co-insurance. This authorization is valid as long as I am a patient of this practice. I understand that if I do not keep a scheduled appointment or call to cancel ahead of time, I may be charged a \$25.00 fee for a missed office visit or \$75.00 for a missed testing appointment.



SIGNATURE (Patient, Parent, Legal Guardian, Healthcare POA)

DATE

HIPAA - ACKNOWLEDGEMENT AND CONSENT

The undersigned hereby acknowledges that they have personally received a copy of the Notice of Privacy Practices for the offices of *Advanced Neurologic Associates, Inc.* In compliance with HIPAA regulations, the undersigned acknowledges that we may discuss or release, as appropriate, the patient's Protected Health Information with any entities stated in the Privacy Notice, and otherwise only those parties specified by the patient, parent if a minor, legal guardian or healthcare POA. The signature below authorizes *Advanced Neurologic Associates, Inc.* healthcare providers to discuss your care for the purposes listed below. This includes confirming appointments or leaving appointment reminder messages on voice mail or answering machines.

Your signature below (or any facsimile of this signed authorization) may be used for the following reasons:

- Treatment - coordination of care with other providers and facilities involved in your healthcare.
- Payment – information to third party payers regarding your treatment
- Healthcare Operations – to determine the best course of treatment for the patient and to plan and coordinate our practice operations to serve all patients in the most efficient and accurate manner possible.

In addition I authorize Advanced Neurologic Associates, Inc. employees and physicians to communicate with the authorized representatives I have listed below. This authorization DOES NOT authorize these representatives to make healthcare decisions for me.

Name

Relationship

Phone

Name

Relationship

Phone

Name

Relationship

Phone



SIGNATURE (Patient, Parent, Legal Guardian or Healthcare POA)

DATE

*****These authorizations are valid until revoked in writing.**