Consent to Treat and Health Care Agreement

1- Consent to Treat:

I hereby consent to management, evaluation, diagnostic procedures, testing, and treatment as directed by Dr. Yessar Hussain or his designee. I understand that Austin Neuromuscular Center has teaching affiliations and therefore I may be attended to by students and residents of various educational programs. I understand that I may request and receive information on the specific affiliation of any health care provider I encounter during my care. **I understand that this consent to treat will be valid for each visit I make to the Austin Neuromuscular Center until revoked by me in writing.**

2- Consent to Release Information:

I acknowledge that Austin Neuromuscular Center may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Austin Neuromuscular Center Notice of Privacy provides Information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but not limited, information related to my health history, diagnosis, treatment, prognosis, mental illnesses (exclude psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Austin Neuromuscular Center

I acknowledge and consent to allow Austin Neuromuscular Center to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but not limited to, treatments, prescriptions, labs, medical and prescriptions history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems.

I authorize my primary care provider, referring physician and other care providers to furnish any and all information concerning my present illness to Austin Neuromuscular Center.

3- Assignment of Insurance Benefits:

I assign and transfer to Austin Neuromuscular Center all rights, title and interest in payments from third party payers, including but not limited to, health plans, health insurers, Personal Injury Protection plans, auto or home owner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are covered benefit.

4- Medicare/Medicaid/Insurance benefits:

If I am eligible for healthcare benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or contractors any information needed for any federal or state program related claims.

I request that payment or authorized benefits be made to Austin Neuromuscular Center on my behalf. I understand that I'm financially responsible for any deductible, copayment, and balance due under these programs.

5- Consent to photograph/digital imaging:

I consent to photograph/digital images for treatment, education, and to verify identity for payment purposes. I understand that Austin Neuromuscular Center will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

6 - Accidental Exposure of Healthcare Worker:

I understand that Texas law provides and I give consent that in the event of healthcare workers exposed to my blood or body fluids, my blood may be tested for HIV antibody and other communicable disease at no cost to me.

7- Privacy Notice:

I have read and acknowledged Austin Neuromuscular Center Notice of Privacy Practices. A copy for my records will be provided at my request. Austin Neuromuscular Center complies with all regulatory guidelines with regard to safeguard your protected health information.

8- Please list any authorized healthcare providers or persons (eg. family members) with whom we can share your protected health information:

Name: ____ Relationship: ____________________

Name: ____ Relationship: ____________________

Name: ____ Relationship: ____________________

9- ACKNOWLEDGEMENT AND AUTHORIZATION:

1- I hereby assign my insurance benefits to be paid directly to the healthcare provider.

2- I authorize athenahealth (our medical billing company) to release medical information required to process my claim.

3- I authorize athenahealth (our medical billing company) to obtain/have access to my medication history.
4- **I authorize my provider's office to contact me by mobile phone.**

____ ______________________________
Patient Printed Name Patient DOB

____ ______________________________
Patient/Responsible Party Signature Date

____ ______________________________
Witness Date