AUSTIN
NEUROMUSCULAR
CENTER

CONSENT TO TREAT - HEALTH CARE AGREEMENT

I hereby consent to management, evaluation, diagnostic procedures, testing, and treatment as directed by Austin Neuromuscular Center physicians & associates or 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 Austin Neuromuscular Center until it is revoked by me in writing to the clinic.**

I acknowledge that Austin Neuromuscular Center may release my protected health information as necessary for treatment, payment, and health care operations and acknowledge that the Austin Neuromuscular Center Notice of Privacy Practices 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 is not limited to 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 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 is not limited to treatments, prescriptions, labs, medical and prescription 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 provider, and other care providers to furnish all information concerning my present illness to Austin Neuromuscular Center.

I authorize Athenahealth (our medical billing company) to release the medical information required to process my insurance claims and to obtain/have access to my medication history.

I consent to photographs/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 and/or obtain copies.

I understand that Texas law provides, and I give consent that if healthcare workers are exposed to my blood or bodily fluids, my blood may be tested for HIV antibodies and other communicable diseases at no cost to me.

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

Please list any authorized additional healthcare providers or persons (example – family members) with whom you give permission to Austin Neuromuscular Center to share your protected health information:

Name: ______________________________Relationship: _______________________________

Name: ______________________________Relationship: _______________________________

Name: ______________________________Relationship: ______________________________

I understand that it is my responsibility to update this list if circumstances change.
I have read, understand, and agree with the information listed above. I also agree that such terms may be amended from time to time by Austin Neuromuscular Center.

Patient name: ____

Signature: ____

Date: _____________

If other than the patient, relationship to the patient (for minors):

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