Minnesota Epilepsy Group, P.A.

225 Smith Avenue N., Suite 201 – St. Paul, MN 55102 – Phone (651) 241-5290 – Fax (651) 241-5248

CONSENT AND PAYMENT AUTHORIZATION FORM – Revised 9-14-2016

Payment Authorization

Payment Responsibility: I agree to pay for all services furnished to me by Minnesota Epilepsy Group, P.A. ("MEG"), including, but not limited to, nurse phone calls, late and/or no cancellation fees, charges that are not paid in full by my insurance, government program benefits or other third-party payers, upon receipt of a statement, except as prohibited by MEG's contract with my health plan or applicable law. I also agree to pay or reimburse MEG for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees.

Release of Information by MEG for Payment and Healthcare Operations: I consent to the release of my health records and other information related to my health care services for payment and healthcare operations purposes. I agree that my health records and other information may be released to Medicare, my insurance company or health maintenance organization, other payers, other providers involved in my care (including group home, nursing home, social worker, school nurse or other care provider), payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties.

Consent for Research: I consent to the use of information in my MEG medical record for scientific research purposes. I understand that my name or other identifying information will not be used and my identity will remain anonymous.

External Prescription History Consent: I authorize MEG to view and obtain my external history via eClinicalWorks. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here at MEG, and may include prescription information for up to 2 years prior to the present date. My signature certifies that I have read and understand the scope of my consent and I authorize the access.

Notice of Privacy Practices

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

Confidentiality: It is the policy of MEG to protect the privacy and confidentiality of patients' medical information.

Notice of Privacy Practice: MEG's Notice of Privacy Practices explains how MEG may use and disclose my medical information. It also explains my rights regarding this kind of information. MEG may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. MEG's Notice of Privacy Practices is available at www.mnepilepsy.org – select the Patient Resources tab – select Patient Forms.

Revocation: I understand that this consent is valid for one (1) year, unless I revoke it at an earlier date, which I may do at any time by giving written notice to: **Laurie Colbeck, Medical Records, Minnesota Epilepsy Group, P.A.**

Acknowledgment of Receipt: I acknowledge that I have been offered MEG's Notice of Privacy Practices and:

Please initial one:____ Accepted a copy _____ Declined a copy

☐ Please mail me a copy of MEG's updated Notice of Privacy Practices.

****I consent to the release of information about me and to discussion of my medical care with the following individuals (designated by patient): ****

Name:_____ Relationship To Patient:_____DOB_____

Name:_____ Relationship To Patient:_____DOB_____

PATIENT'S NAME (please print):_____DATE OF BIRTH:_____

SIGNATURE OF PATIENT (if applicable): _____ DATE: _____

***must be renewed one year from this date**

NAME OF LEGAL GUARDIAN (if applicable) (please print): _____

SIGNATURE OF LEGAL GUARDIAN (if applicable): _____DATE: _____