

Privacy notice:

The Neurological Group has an obligation to maintain the privacy of your protected health information. A copy of the Neurological Group’s Notice of Privacy Practices detailing how your information may be used and disclosed, as permitted under federal and state laws, has been made available to you. You may request a copy of the notice and may contact the privacy officer with any questions.

Permissions:

The provider and staff of the Neurological Group recognize and respect your right to privacy concerning your protected health information. We will not discuss your medical issues, including appointments, billing or medications without your permission. If you wish to allow us to discuss your health information with any individual, please list them below:

Name	Relationship
_____	_____
_____	_____
_____	_____

Advance Care Plan:

Do you have an Advanced Care Plan? Yes ___ No ___

Do you have a Surrogate decision maker? If yes, please name: _____

Preferred contact information:

We may contact you by phone, text, mail or portal message to remind you of appointments or provide information about treatment or test results. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence. If you have a preference, please check below:

Home _____ Cell _____ Work _____

Allow text messaging regarding appointments? Yes or No

I give consent for the Neurological Group, PC, its providers, agents and contractors, including debt collection agencies which we may engage, to place calls to your designated phone numbers using any type of artificial or pre-recorded voice or auto-dialer technology for any purpose permitted by law. You are not required to agree to this section in order to receive services from the Neurological Group.

By signing below, I acknowledge that I have read and understand the Neurological Group’s policies and procedures as outlined above regarding privacy, permissions and patient contact.

Signature of patient or legal representative

Date

Printed name of patient and/or legal representative