



PATIENT CONSENT FOR TREATMENT

Please initial each section.

Parent/Guardian Consent: We require the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18. Please note: We do not see patients under the age of 18 years old without an adult accompanying them and strongly encourage a parent or legal guardian to attend all visits.

Consent for Medical Care: I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Crescent Neurology and Sleep, LLC and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Crescent Neurology and Sleep, LLC.

Assignment of Benefits: I assign to Crescent Neurology and Sleep, LLC my right to receive payment from third-party payers. Third-party payers include payers (such as insurance carriers or social security administrators) who provide coverage to me for care provided by Crescent Neurology and Sleep, LLC.

Responsibility of Payment: I will pay for all my care provided by Crescent Neurology and Sleep, LLC. and not paid for by third-party payers. I will pay for my care even if a third-party payer determines whether the care was medically unnecessary or not covered, or if a third-party payer denies authorization, either before or after the care was provided. I agree that the fees for my care will be determined by reference to the charge master of Crescent Neurology and Sleep, LLC. If I am sued to collect payment for my care, I will pay all costs, including reasonable attorney and/or collection agency fees, and interest in the amount of the lesser of either 1.5% per month or the maximum amount allowed by law.

Disclosure of Medical Information: I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Crescent Neurology and Sleep, LLC. I authorize Crescent Neurology and Sleep, LLC and medical staff to divulge my medical information for the provision, coordination or management of health care and related services. For example, Crescent Neurology and Sleep, LLC and the medical staff may share medical information about me with other health care providers to coordinate different treatments, such as prescriptions, lab work and x-rays or to assist subsequent health care providers in treating me. I authorize Crescent Neurology and Sleep, LLC and the medical staff to divulge my medical information to obtain payment for services provided to me. For example, Crescent Neurology and Sleep, LLC and the medical staff may send a bill, including my medical information, to a third-party payer. I authorize Crescent Neurology and Sleep, LLC and the medical staff to divulge my medical information as necessary to run Crescent Neurology and Sleep, LLC and make sure that all its patients receive quality care. For example, Crescent Neurology and Sleep, LLC and the medical staff may share my medical information or use it to create a health information database to assess the care and outcome in my case and others like it.

Medications: I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

Valuables: I agree that Crescent Neurology and Sleep, LLC is not responsible if my belongings are lost or damaged during my time at the medical practice.

Notice of Privacy Practices: Crescent Neurology and Sleep, LLC and the medical staff's notice of privacy practices more fully describe the ways in which they may use and disclose my medical information. The notice also describes my rights and their legal obligations regarding my medical information. By initialing here, I acknowledge that I have been given a copy of Crescent Neurology and Sleep's notice of privacy practices.

Mandatory Recording Consent and Release: It is a requirement that all sleep studies conducted at this sleep center contain audio and video recording for purposes including patient monitoring, diagnostic evaluation, and quality assurance. I understand that these recordings are the property of Crescent Neurology and Sleep and will be stored securely, with access limited to authorized personnel only. By signing below, I consent to being recorded during my sleep study and release the sleep center, its staff, and affiliates from any liability related to the recording process.

Patient Choice Acknowledgment: I understand that I have the right to select my medical equipment supplier and treatment facility for sleep related services. Crescent Neurology and Sleep is available to coordinate and collaborate with the supplier I choose and to assist me throughout my treatment. CNS will provide guidance and support as appropriate but will not influence or restrict my selection of supplier or equipment.

Parking & Premises Disclaimer: By entering Crescent Neurology and Sleep and its grounds, including the building, parking lot, and surrounding areas. I acknowledge that I am responsible for my own safety and belongings. The sleep center, its staff, and affiliates are not liable for any loss, theft, damage, accident, or injury that occurs on the property, and I release them from any related claims.

I have read the information on this form or have had it read to me. I have had the opportunity to ask any questions I might have. By voluntarily signing my name below, I indicate that I understand and accept each of these provisions.