HIPAA FORM

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my healthcare, Dr Supriya Thirunarayanan M.D, maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A source for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of the uses and disclosures of my health information. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereof. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by 45 CFR Section 164.506 of the Code of Federal Regulations.

I further understand that Dr Supriya Thirunarayanan M.D. reserves the right to change their practice policies and prior to implementation, in accordance with 45 CFR Section 164.520 of the Code of Federal Regulations. Should Dr Supriya Thirunarayanan M.D. change their notice, they will send a copy of any revised notice to the address provided (whether U.S. mail, if I agree, e-mail).

I understand that Comprehensive Neurology Center PA(CNCPA) has established a Notice of Privacy Practices which provides information about how my protected health information can be used and disclosed. I consent to the use of my protected health information for the treatment, payment, and health care options.

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I,_____the undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my designated authorized representative, Comprehensive Neurology Center, PA (the "Provider"), and/or designated business associates, the right to pursue payment for all benefits entitled under my plan or policy. This authorization includes, taking any and all necessary steps, including pursing administrative appeals, requesting disclosures and remedies, filing suit and all causes of action and all other protected rights wholly in my stand, for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate and that I am responsible for keeping it updated. I hereby authorize provider. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) to be paid in full compliance of governing laws. I further authorize my plan, its fiduciaries, and/or its third-party administrators to release to my health care provider, and/or the Provider's appointed business associates, all EDI and other information necessary for my healthcare provider to claim such benefits. I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation stating such non-assignment to myself and the provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I understand there are state and federal consumer protections that support even for out of network providers that may be associated with my care or surgery, that I am responsible for co-payments,co-insurance, and deductibles at no more than my in-network cost share rate. I understand, agree, and hereby certify that I am obligated to pay, as charged, and billed for global service charges, regardless of if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: *"The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,"* and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against any unexpected medical bills or charges by my provider's applicable ACA or indigency discount policy; including any non-compliant or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's initiative-taking reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment..

I hereby designate, authorize and appoint the Provider, it's attorneys or other designated business associate as my authorized representative to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) To file and participate in any administrative or judicial review process; (4) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a). (5) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (6) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and
(7) allow a photocopy of my signature to be used to process insurance claims. This authorization will remain in effect until all benefits are paid in full compliance with applicable federal and state laws.

I hereby confirm and ratify all actions taken by my authorized representative pursuant to the authority granted herein. I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all relevant Plan and claim related documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys or designated business associates in order to secure and claim such medical benefits due and owed me under my plan or policy. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process. I understand that I will be held financially responsible for all fees accumulated for collection agency fees. Administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. This order will remain in effect until revoked by me in writing. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it were the original. I understand that, by signing this form, I am confirming my appointment of my designated authorized representative, the scope of my authorized representative's authority, and the option of revocation of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient/Guardian/Insured Signature:_____Date: _____

Employer Group Name Covering Benefits: _____

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