2121 E. Harmony Road, Suite 180
Fort Collins, CO 80528

I, _____ do hereby request and consent to the provision of health services by the staff of Advanced Neurology of Colorado, LLC. I understand that those services provided may include examinations, diagnostic testing, x-ray examinations, therapies and other services which are determined to be advisable and are to be rendered under the general or special supervision of a physician. I am also consenting to the provision of health services which may be provided to me by other specialized personnel who may not be employees of Advanced Neurology of Colorado, LLC. All such persons are independent contractors and are not agent of Advanced Neurology of Colorado, LLC. And Advanced Neurology of Colorado, LLC has no responsibility to me for their acts or omissions. I understand that specialized personnel acting as independent contractors are also responsible for billing their services independently from Advanced Neurology of Colorado, LLC and any financial arrangements made with respect to my Advanced Neurology of Colorado, LLC bill are separate of distinct from any bills I may receive from others. Certain procedures and tests may require separate consent forms.

It is understood that this authorization is given in advanced of any specific diagnosis, treatment or care being required, but it is given to provide my physicians with authority and power to provide any and all such medical, dental, emergency health and surgical care of treatment which the physicians, in the exercise of their best judgment, may deem advisable.

I acknowledge that no guarantees have been made to me as to the results of the examinations, treatment or therapies provided by Advanced Neurology of Colorado, LLC.

I understand that I may revoke my consent at any time by a written notice. In the absence of my formal written notice this consent is revoked automatically 12 months from the date of my initial signature.

Release of Medical Information: Advanced Neurology of Colorado, LLC may disclose all or any part of my medical records to any Payor, which is, or maybe, liable under contract for all or part of the Advanced Neurology of Colorado, LLC bill. "Payor" includes medical services companies, insurance companies, health care service plans, managed care companies, workers compensation carriers, the Social Security Administration, the intermediaries or carriers, charitable assistance funds or any employer, if that employer is self-insured. Any additional medical information requested other than that necessary to pay a claim or to pre-authorize a service will require a specific consent for release of that information and will be administered by the medical records department of Advanced Neurology of Colorado, LLC.

Assignment of Benefits: If I am entitled to benefits of any type whatsoever arising out of any insurance policy or public entitlement insurance or any other party liable to me, such benefits are hereby assigned to Advanced Neurology of Colorado, LLC for application to my bill. I understand that billing of insurance or other benefits is a service only and is not a guarantee of payment. If the Payor does not pay within sixty days of billing, I shall be financially responsible for the full amount of the bill. I will also promptly furnish, complete and sign any forms that may be necessary to obtain reimbursement for a Payor to Advanced Neurology of Colorado, LLC for services rendered.

Notice of Privacy Practices & Patient Rights: By signing below, I acknowledge that I have received a copy of the Patients' Rights and Responsibilities and Notice of Privacy Practices. I give my consent to Advanced Neurology of Colorado, LLC to use and disclose my Protected Health Information ("PHI") as described in the Notice and as allowed by law. I also understand that my health information will be exchanged electronically with other healthcare providers through the Colorado Regional Health Information Organization and acknowledge that I may change my participation status at any time.

Managed Care Statement: I recognize that Advanced Neurology of Colorado, LLC may not be considered a preferred provider by my managed care health insurance plan. I accept full financial responsibility for any charges not covered by my insurance as a result of my seeking services from a provider outside of my plan.

Financial Agreement: I agree to pay to Advanced Neurology of Colorado, LLC all co-payments at the time the service is rendered. I understand that if I have not insurance coverage, payment is due at the time of service unless prior arrangements have been made. Advanced Neurology of Colorado, LLC accepts, cash, check, Visa, MasterCard and Discover. Payment plans are accepted upon prior approval. I understand that unpaid balances will be considered delinquent after 60 days. All returned check will be assessed a $20.00 return fee for processing. I also agree to pay any independent provider for services rendered to me and understand that such provider will bill me separately from the Advanced Neurology of Colorado, LLC bill.

Mutual Respect Policy

Our staff makes a sincere effort to treat every patient in our clinic with respect and professionalism. Please treat all members of our staff with the same courtesy you would expect from them.

_____ _____

Patient or Legal Guardian Date

_____ _____

Witness Signature Date