# 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 September 23, 2013

## 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 payors, 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.

**Payment Authorization:** I authorize MEG to directly bill my health plan or third-party payor for services rendered to me by or on behalf of MEG, but acknowledge that MEG is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to MEG for such services. If I have a Medigap policy, I request that payment of authorized Medigap benefits be made to MEG directly on my behalf by my Medigap insurer. I understand and agree that MEG is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

**Statement to Permit Payment for Medicare Benefits to MEG:** If I am entitled to Medicare benefits, I request payment of authorized Medicare benefits to me, or on my behalf to MEG, for any services furnished to me by or in MEG, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

## Release of Information

I consent to the release and use by MEG of medical and other information about me to the extent permitted by law to the following:

- To a health care provider (including Group Home, Nursing Home, Social Worker, School or other care provider) being advised or consulted in connection with my treatment or care;
- To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
- To a person or organization in connection with MEG's health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.

**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

**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.**

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**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:_____

Name:_____ Relationship To Patient:_____

**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: _____**