FOUR CORNERS
CENTER FOR NEUROLOGY SPECIALTY
BETTER BRAINS. NICER NERVES.

Patient Consent for Medical Treatment

I, _____, hereby consent to outpatient care and treatment performed by providers at Four Corners Center for Neurology Specialty. I also consent to routine services, diagnostic procedures, medical treatment, and other healthcare services as deemed necessary by my healthcare provider during either face-to-face or telehealth visits. I understand I have the option to refuse the delivery of health services via telemedicine at any time without affecting the right to scheduling future appointments.

I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent to or to refuse to consent to any procedure or treatment offered by my healthcare provider and to discuss these options with my healthcare provider. I also understand that during my medical treatment, I may have one or more photographs or videos used in monitoring my treatment and guiding healthcare provider interventions.

I understand that individuals who want to learn about the roles of healthcare providers may observe the treatment I receive. I consent to this but I have the right at any time to object to letting such an individual observe where my objection will be honored. I understand that if I am participating in a research protocol and have signed an Institutional Review Board (IRB)-approved consent form, all provisions of this Patient Consent for Medical Treatment shall apply to those tests and services not included within the research protocol.

Patient Name: _____

Patient Signature: _____

Date: _____

Authorization for Release of Information

I, _____, authorize Four Corners Center for Neurology Specialty to utilize confidential medical information contained in my medical record as necessary for medical management, chart review-based research, review-based quality of care, and/or insurance authorization (if applicable for prescriptions, etc.). I further authorize the release and discharge of such confidential information to my insurance company or other health coverage plan, including government payers, as necessary for medical management and quality review activities conducted by such company or plan, or its designees. This authorization includes the release of relevant infectious antibody test results, alcohol and/or drug abuse information, genetic testing, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time, but only with respect to the proposed treatment and not with respect to care and treatment that has already been rendered to me. I understand that I shall have access to all medical information resulting from the telemedicine services provided.

Patient Name: _____

Patient Signature: _____

Date: _____

Office Policies

Cancellation Policy

Any cancellation made 48 hours or more from the time of the appointment will incur no cost. Cancellations made less than 48 hours of the scheduled appointment are subject to the "No Show" policy fee of $50. This fee can be waived if an appointment is changed to another available time on the same day upon approval by the office. If you are more than 15 minutes late, you will be asked to reschedule and may be charged a "No Show" fee.

"No Show" Policy

A "No Show" occurs when a patient misses a scheduled appointment without giving notice to our office at least 48 hours ahead of the scheduled time. Each "No Show" incurs an expense as follows:

- The first "No Show" is $50 for the missed appointment.
- The second "No Show" is one-half of the cost of the scheduled appointment.
- The third "No Show" and those thereafter will be at the full cost of the appointment.

This policy remains in effect for the duration of the physician-patient relationship. Incurring more than three "No Show" appointments can lead to patient dismissal from our office.

Card Holding Policy

Four Corners Center for Neurology Specialty will not hold payment card information. However, we use third-party payment platforms that may safely retain your card information to make payments at or before the time of the appointment. Charges will not be incurred without your knowledge and will correspond with a scheduled appointment or service.

Patient Dismissal Policy

Respect is expected by patients, providers, and staff. Disrespectful, threatening, or inconsiderate behaviors by a patient can lead to dismissal from the practice. If such an unfortunate incident occurs, the patient will receive one warning at the discretion of our office, which can include a verbal warning from a staff member. Subsequent offenses can lead to dismissal. A patient will be notified of dismissal by a certified letter that is signed by the provider with a brief explanation of the cause. The provider will allow at the provider's discretion for continued care in the form of medication refills while the patient transitions from our care to another office. Four Corners Center for Neurology Specialty is not subject to Medicare rules and regulations and reserves the right to refuse care at anytime for any reason at the discretion of the provider.

Payment Policy

Four Corners Center for Neurology Specialty does not accept insurance, Medicare, or Medicaid at this time. If you are a patient with Medicare, you are *required* to complete the Waiver of Medicare Payment form included below, as you **cannot** submit for reimbursement any costs incurred at our office to Medicare.

Payments made for all services at Four Corners Center for Neurology Specialty are final. Payments for our consultation and/or procedural services are not subject to refunds. We accept payment by major credit cards, ACH, or checks. Checks that return for any reason are subject to a service charge of $25 in addition to the remaining balance.

Insurance Policy

Four Corners Center for Neurology Specialty does not accept insurance at this time. As such, we **will not** submit payment requests nor reimbursement requests to insurance providers for the services provided at our office. Our office is not responsible for any submission by the patient to their insurer for repayment. Our office may order labs, studies, and/or medication that may be covered by the patient's insurance policy when such services are performed by third-parties outside of our office. Patients would have to independently confirm coverage with his or her insurers and third-party providers regarding labs, studies, and/or medications provided outside of our office. However, our providers will make a diligent effort to obtain approval or have approval obtained by the third-party when requesting diagnostic test, study, and/or medications.

Research Policy

A primary focus of Four Corners Center for Neurology Specialty involves both internal and collaborative research related to the practice of medicine and neurology. Our office may use your de-identified data to perform research that helps identify a more effective means of diagnosing and/or treating neurological diseases and disorders. This research will comply with HIPAA and other federal and state regulations. This consent will in no way affect your treatment. There is minimal to no risk to you in consenting to our use of your de-identified data. Any personal identifiable data will not be shared outside our organization without your explicit consent.

Research efforts can lead to improvements in care, which may later benefit you. However, there is no immediate benefit to you through this consent. For any research study that includes any procedures, identifiable genetic data, or tissue such as blood that you volunteer to participate in, a separate consent form under the review of an Institutional Review Board (IRB) will be provided to you. Your participation is fully voluntary. You may notify our office if you would like to be excluded from any of our research efforts. You may also be excluded from this research by our office for a variety of reasons.

Patient Paperwork Policy

Paperwork such as medical clearance and driver's license-related forms are often necessary or important to the everyday life of the patient. We will complete trivial one-page forms at no additional cost to you. However, completion of complex forms requested for disability or other purposes will incur a time-dependent charge commensurate with the cost of a one-hour consultation fee. Form completion will depend upon the patient's presentation during prior visits. Therefore, we will not complete a form without evaluating a patient during initial and/or follow-up consultations.

Social Media and Communication Policy

Our office may have an identifiable presence on Facebook, Instagram, Twitter, or any other platform used for the free distribution of information and communication services (a.k.a. social media). These services are not considered secure or confidential. Hence, we request that communications on any of these platforms not contain confidential or personal health information. This is to maintain compliance with state and federal privacy requirements and regulations.

Our office does maintain appropriate and confidential means of communications including by phone, by fax, or by sender-encrypted email sent to Office@FourCornersCNS.com. Please note that SMS and MMS (text messages) are not considered a secure means of communication.

Acknowledgement

I hereby acknowledge receipt of, understand, and agree to these policies. An electronic copy of these signed documents is available to me and will be retained for my own records. I understand that policies are subject to change. The most current version can be found at https://www.fourcornerscns.com where I may not be notified of any changes made to our policy.

Patient Name: _____

Patient Signature: _____

Date: _____

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Waiver of Medicare Payment

If you are a patient with Medicare, you must complete this form.

This agreement is between Dr. David Rushworth, M.D., Ph.D., whose principal place of business is 555 Rivergate Lane, Suite B1-102, Durango, CO 81301 and

Beneficiary's Name _____
Beneficiary's Address _____
_____
Beneficiary's Medicare ID # _____

who is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following: *(Initial below)*

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him/her.

Executed on _____ *(date)* by

_____ *(signature)*
Beneficiary or his/her legal representative

and

_____ *(signature)*
Dr. David Rushworth, M.D., Ph.D.