

The Neurology Center

7505 S. Main, Suite 290 · Houston, Texas 77030
(713) 795-0074 (713) 795-5203 Fax

Julia L. Jones, M.D.

Igor M. Cherches, M.D.

Steven M. Lovitt, M.D.

Greg S. McLauchlin, M.D.

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I, _____, have received a copy of
(Print Name of Patient or Parent/Guardian)

The Neurology Center Notice of Privacy Practices.

Signature of Patient or Parent/Guardian

Date

Consent for Use and Disclosure of Protected Health Information

I consent to the use and disclosure of my Protected Health Information for treatment, payment, and healthcare operations. This includes HIV and substance abuse information. If I am the patient's parent of guardian, then I am consenting on behalf of the patient.

Signature of Patient or Parent/Guardian

Date

Assignment of Benefits/Authorization of Payment/Signature on File

I authorize payment of medical insurance benefits to The Neurology Center PA.

I understand that, according to the provisions of my insurance plan, I may be billed for amounts not covered by that plan, and accept full financial responsibility for any such fees.

Signature of Patient or Parent/Guardian

Date

- ***We bill \$25.00 or office visits cancelled within 24 hours of the scheduled time.***