VAUGHT NEUROLOGICAL SERVICES, PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

_________ I have received a copy of Vaught Neurological Services, PLLC Notice of Privacy Practices.

Acknowledgement of After Hours/Appointment No-Show Policy

_________ I have read Vaught Neurological Services, PLLC Appointment No-Show Policy, which is as follows: I understand that after the first no-show I will be given the opportunity to reschedule my appointment. However in the event of two no-shows, I will be unable to schedule another appointment at this office.

Authorization to Release Medical Information to your Physicians

_________ The undersigned authorizes Vaught Neurological Services, PLLC to release information from the patient's medical records to any referring physician, to any healthcare facility to which the patient may be transferred, and/or to any healthcare provider involved in the patient's care.

Unless otherwise restricted by applicable law, this authorization to release medical records includes the release of medical record information for all health care services that previously have been or will, in the future, be provided by Vaught Neurological Services, PLLC, and this authorization to release medical records is not restricted to those health care services rendered in connection with this visit and may include information gathered from other heath care providers.

Acknowledgement of Provider Resource Scheduling

________ I understand that Vaught Neurological Services, PLLC utilizes mid-level providers (nurse practitioners and physician assistants) and I may see one of these providers in addition to or instead of Dr. Vaught at my follow-up visits. The scheduling of follow up appointments with other providers at Vaught Neurological Services, PLLC may vary depending on my diagnosis and current symptoms at the time the appointment is made.

Request to Inspect and Copy Protected Health Information

________ I understand and agree that I am financially responsible for the following fees associated with my request: Copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the minimum charge for this service is $10.00, with a $0.25 per page charge for each page exceeding 10 pages.

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Patient or Designated Surrogate Signature Date

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Patient or Designated Surrogate Printed Name