Neuropsychological Services of Virginia

Authorization to Release Information

I authorize the release of any medical or other information to my insurance carrier(s) or to any entity necessary to determine insurance benefits payable for related healthcare services and/or supplies provided by Neuropsychological Services of Virginia.

Initial Here: _____

Assignment of Benefits

I authorize direct payment of all insurance benefits, including Medicare, to Neuropsychological Services of Virginia for all covered healthcare services and supplies provided to me by Neuropsychological Services of Virginia and/or its affiliated entities. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Neuropsychological Services of Virginia and will constitute a continuing authorization, maintained on file with our office, which will authorize and allow for direct payment of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Neuropsychological Services of Virginia.

Initial Here: _____

Advance Care Planning

I have an Advanced Care Plan and/or surrogate decision maker in place if for some reason I am unable to make healthcare decisions on my own accord.

YES ☐ **NO** ☐ Initial Here: _____

IF YES, WHO? _____

Notice of Patient Privacy Practices

I acknowledge that I was provided the opportunity to review a summary of Neuropsychological Services of Virginia's Notice of Privacy Practices (NPP). I also acknowledge that I have been allowed to ask questions concerning this notice and the rights under this notice and may receive a complete copy of the NPP upon request. I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial Here: _____

HIPAA Consent

I understand that HIPAA requires Neuropsychological Services of Virginia's (NSV) providers and staff to verify identities when speaking with unknown family members and friends. I understand the doctors and staff of NSV may not have access to this disclosure information at certain times such as after-hours and on weekends, and I agree they should use their professional judgment and discretion at such times with respect to sharing my personal health information, including emergency situations where I may be unable to provide consent. I also understand that NSV may request and release information to and from treating providers as well as new referrals for necessary treatment.

Initial Here: _____

Disclosures related to my health or as needed for payment for healthcare services may be made to the following family members and friends:

NAME	PHONE NUMBER	RELATIONSHIP	DATE OF BIRTH

I acknowledge the above information has been explained to me and I understand it.

SIGNATURE	
PRINTED NAME	
DATE	