Dear Valued Patient of **KANE HALL BARRY NEUROLOGY**

We value your confidence in our ability to address your specialized healthcare needs. At Kane Hall Barry Neurology, our mission is to lead the way in providing high-quality, compassionate, and patient-centered neurological care to support patients and their families within the Dallas-Fort Worth Metroplex.

The following sections include the essential information required to establish a meaningful partnership between us:

1. Authorization & Consent to Treatment
2. General Office Policies
3. Financial Policy
4. Assignment of Benefits
5. Release of Billing Information
6. Medication History Authority

Compliance with these policies is ***mandatory*** to receive medical services at our facility.

Thank you for choosing Kane Hall Barry Neurology.

1. <u>Authorization & Consent to Treatment</u>

a. The patient voluntarily consents to the rendering of such care and treatment as the providers, in their professional judgment, deem necessary for their health and well-being. Patient consent covers medical examinations, diagnostic testing, infusion treatments, minor surgical procedures, and injections. Consent covers the treating provider and care center staff. The patient acknowledges that neither the provider nor any of his or her staff have made any guarantee or promise as to the results of treatment. Participation in a telehealth visit (phone or virtual), indicates consent to its recording and the patient may terminate such visit at any time.

b. **Clinical Trials/Research:** Kane Hall Barry may refer patients for clinical trials/research. Participation is completely voluntary and care from Kane Hall Barry is not affected based on participation.

c. **Disclosure of AI use:** Per Texas SB 1188 - Kane Hall Barry may use AI tools to assist with the diagnosis/treatment plans for patients. In such circumstance, rest assured that the practitioner will also review any records created by AI in a manner consistent with medical records standards.

2. **<u>General Office Policies</u>**

a. **Patient Identification:** To enhance identity protection in compliance with the Federal Trade Commission's "Red Flag" rule, our office will require a valid photo identification from all patients upon check-in. If, at the time of your visit, you are unable to provide proper identification, we will need to reschedule your appointment and late cancellation fees may apply.

b. **Minors:** For patients under the age of 18, it is mandatory for a parent or guardian to be present during the visit, and to be responsible for the full payment of services.

c. **Prescription Refills:** Patients should call their pharmacy to request refills – if a visit is required, we will contact the patient to schedule. Please allow 5 business days for medications to be filled. Refills requiring a prior authorization take a minimum of 10 days.
d. **Consent to Call, Email & Text:** The patient understands and agrees that the office may contact them using automated calls, emails, and/or text messaging. These communications may include notification of appointments, test results, treatment recommendations, outstanding balances, office closures, or any other communications from the office. The patient understands that he/she may opt out of receiving all such communications by notifying office staff, adjusting portal settings, and/or replying "STOP".
e. **Privacy Notice:** The patient understands that the Privacy Notice is available at kanehallbarry.com or by request .
f. **Health Information Exchange (HIE):** To ensure comprehensive coordination of care, this office has adopted a Health Information Exchange (HIE) policy with opt-in by default. This means that, by default, patient health information can be shared among a trusted network of healthcare providers. If the patient prefers to opt out of this system, please notify staff.
g. **Weapons Policy:** Guns, firearms and weapons are prohibited in our facilities.
h. **No Photo or Recording Policy:** To maintain patient privacy while in our office, we do not allow photos or video recordings.
i. **Service Dogs:** Service animals, defined by the ADA as a dog that is trained to perform work or tasks for people with disabilities, are allowed. No other pets/animals are allowed including emotional support, therapy and/or comfort animals.

3. **<u>Financial Policy</u>**
   a. **Paying for your visit:** We are committed to understanding patient benefits and to providing a cost estimate before providing services. Estimates are just that – estimates. Things can, and do, sometimes turn out differently, and we appreciate timely payment of any outstanding balances. With that in mind, please inform us of any changes in patient information such as name, address, phone number, and/or insurance before appointments. If we are unable to verify insurance before a visit, the patient is responsible for the full payment due at the time of service.

   When checking in we will collect co-pay, deductible, co-insurance, and/or any balances left on the account from previous visits. If the patient has any questions, please call before the appointment so there are no surprises at check-in.

   Upon request, uninsured patients have the right to receive a "Good Faith Estimate" explaining how much their medical care will cost.

   If a patient is unable to pay for services, we suggest contacting Care Credit before the visit for financing options. They can approve applications before an appointment, typically within

minutes of submitting the information, allowing patients to pay over time. To learn more, visit www.carecredit.com or call 1-800-677-0718.

We accept payment via Visa, MasterCard, American Express, Discover Card, apple pay and CareCredit. We do not accept cash or checks in office.

The patient agrees that, to the extent permitted by law, they will reimburse the provider for all costs, expenses, and attorney's fees incurred in an effort to collect payment for services rendered.

b. **Credit Card on File:** We kindly request that all patients provide a valid credit card to be securely stored on file. This credit card on file will be utilized for settling any outstanding balances or charges not covered by insurance. This streamlined approach ensures an efficient payment process. Rest assured, we will provide a 5-day advance notice before auto-processing the card, offering transparency, and allowing the patient ample time to address any concerns.
c. **Auto Insurance Claims/Letters of Protection/ 3rd Party Billing:** Kane Hall Barry does not file 3rd party insurance claims such as those from a motor vehicle accident, or in any instance where another person or entity is offering to pay on your behalf (exception for Workers' Compensation).
d. **Workers' Compensation:** If your visit is due to a work-related incident, it should be filed through your company's workers' compensation insurance. We are not currently accepting new workers' compensation cases.
e. **Medicaid:** We are not accepting new patients with traditional Medicaid as a primary or secondary form of insurance.
f. **Missed Appointments/Late Cancellations:** We understand that sometimes you may need to cancel an appointment due to unforeseen circumstances just as we sometimes need to reschedule your appointment. Notice of 24 business hours allows us to offer that time to other patients who are waiting to be seen. Therefore, if you miss an appointment, or if you cancel or reschedule an appointment with less than 1 business days' notice, we may charge a late cancellation fee of $30 for office visit appointments and $100 for all other appointments (for example toxin injections, infusion treatments, testing, etc.)
g. **Late Arrival:** If you are running late, please let us know so we can work with you to determine the best way to provide your care. If you arrive more than 15 minutes past your scheduled appointment time, we cannot guarantee we will be able to accommodate you and late cancellation fees will be applied.
h. **Pre-Authorizations/Referrals:** While we will do our best to obtain required authorizations and referrals, it is the patient's responsibility to ascertain whether an authorization/referral is required for services rendered. If an authorization is required but not obtained in time for the visit, the patient will be considered uninsured, with full payment due at the time of service.

Patients can choose to reschedule appointments if the authorization/referral is not likely to be available at the time of the visit, however inadequate notice is subject to the late cancellation fee.

i. **Interpreter and Translation Services:** If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least forty-eight (48) hours before your scheduled appointment, you may be charged an additional late cancellation fee from the translation service provider.

j. **Returned Checks:** A $50 return check fee applies.

k. **Paperwork Requests:** Please refer to our website for the most up-to-date information regarding records requests. Fees may apply.

4. **Assignment of Benefits**

I hereby certify that the insurance information I have provided is accurate, complete, and current and that I have no other insurance coverage. I hereby authorize and direct my insurance carriers, including Medicare, private insurance and any other health/medical plan, to issue payment directly to my provider for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amounts not covered by insurance. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers.

Patient acknowledgement

_____ **I acknowledge that I have received and understood the information provided.**

5. **Release of Billing Information**

I authorize the release of medical or billing information needed to facilitate claims. I understand I will be responsible for any services that are not paid/covered by my insurance. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this release of billing information may not apply.

Patient acknowledgement

_____ **I acknowledge that I have received and understood the information provided.**

6. **Medication History Authority**

I authorize my provider to collect and disclose information about prescription medicines that have been prescribed to me. The information comes from a variety of sources including pharmacies and health insurers. Over the counter drugs and supplements may not be included in this history.

_____ **I consent**

ACKNOWLEDGEMENT FORM

By signing below, you acknowledge you have carefully read and agree to the terms described in the above sections:

1. Authorization & Consent to Treatment
2. General Office Policies
3. Financial Policy
4. Assignment of Benefits
5. Release of Billing Information
6. Medication History Authority

and understand that any failure to comply with any of these terms may result in discharge from Kane Hall Barry Neurology.

Printed Patient Name	Patient Date of Birth	Today's Date

Patient Signature

Printed Legal Guardian Name*	Signature of Legal Guardian*	Relationship

*To be signed by the parent if the patient is under 18 or by the legal guardian. Must provide appropriate documentation such as Medical Power of Attorney when signing.

Kane Hall Barry NEUROLOGY

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PATIENT CENTERED QUALITY CARE SINCE 1995

HIPAA PERMISSION AND RESTRICTION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands the contents of the Notice and requests the following:

PERMISSIONS: I **PERMIT** the following individuals to view, discuss, exchange, and/or receive my protected health information. Please enter the person's name, relationship and date of birth or phone number. This will allow us to verify their identity before sharing information. Please put NONE if you do not want to release information to anyone.

Name	Relationship	Date of Birth or phone number

RESTRICTIONS: Please **RESTRICT** the following individuals from viewing, discussing, exchanging, and/or receiving my protected health information. Please enter the person's name, relationship and date of birth or phone number. This will allow us to verify their identity before sharing information. Please put NONE if there are no specific restrictions.

Name	Relationship	Date of Birth or phone number

Restrictions: _____

Name	Relationship	Date of Birth or phone number

Restrictions: _____

The notice and consent will remain in effect until revoked in writing or a new consent is provided.

Printed Patient Name	Patient Signature	Patient Birth Date	Today's Date

*Legal Guardian Signature	Legal Guardian Relationship

*Medical Power of Attorney and/or Legal Guardianship documents are required when signing on behalf of a patient over the age of 18

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