

CLARITY NEUROLOGY AND PSYCHIATRY ("CNP")

INTAKE AND CONSENT PACKET

For Use at Assisted Living Facilities in Texas

1. PATIENT INTAKE FORM

Patient Demographic Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Gender: ____ Social Security Number: ____-____-____

Address: _____ City: _____ ST: ____ Zip Code: _____

Phone Number: _(____)____-____ Email (optional): _____

Insurance Information

Primary Insurance (e.g., Medicare/Medicaid): _____

Policy/Medicare/Medicaid Number: _____ Part: _____

Secondary Insurance (if any): _____

Policy/Medicare/Medicaid Number: _____ Part: _____

Primary Care Physician (PCP)

Name: _____ Phone Number: _(____)____-____

Address: _____ City: _____ ST: ____ Zip Code: _____

Assisted Living Facility

Name: _____ Phone Number: _(____)____-____

Address: _____ City: _____ ST: ____ Zip Code: _____

Facility Contact Person: _____

Emergency Contact

Name: _____ Phone Number: _(____)____-____

Relationship: _____

Responsible Party (if different from patient)

Name: _____ Phone Number: _(____)____-____

Relationship: _____

Medical History

Current diagnoses: _____

Current medications: _____

Allergies: _____

History of neurological or psychiatric conditions:

2. HIPAA NOTICE ACKNOWLEDGMENT & RELEASE OF INFORMATION

initial I acknowledge receipt of **CNP**'s Notice of Privacy Practices.

initial I understand that my medical records and related equipment may be transported by secure means to and from the location of care, and all reasonable safeguards will be used to protect my information in compliance with HIPAA.

initial I authorize **CNP** to release or receive my health information for treatment, payment, or healthcare operations to/from:

☐ My assisted living facility

initial I authorize **CNP** to communicate with staff at my assisted living facility for the purpose of coordinating care, facilitating treatment, and managing medications.

☐ My primary care provider: _____

☐ Family member or other caregiver: _____

Signature: _____ Date: _____
(Patient or Legal Representative)

3. MEDICARE/MEDICAID ASSIGNMENT OF BENEFITS

I understand that **CNP** will document the services rendered will submit claims to your insurance carrier, including Medicare and/or Medicaid, as applicable. I authorize **CNP** to bill Medicare, Medicaid, or my insurance directly for services provided. I assign all insurance benefits to be paid directly to the provider. I also authorize the use and disclosure of your protected health information as needed to facilitate payment for health care services rendered.

I hereby authorize direct payment of medical benefits to **CNP** for services rendered by **CNP** and its providers. I understand that if I am covered by Medicare, Medicare will send me an Explanation of Benefits (EOB), which outlines what services were billed, what services were covered, and how much I may owe, if anything. I understand I am financially responsible for services not covered.

Signature: _____ Date: _____
(Patient or Legal Representative)

4. CONSENT TO TREAT

I consent to receive medical evaluation and treatment, including neurological and psychiatric care, by clinicians of **CNP**. I understand services may be provided on-site at my assisted living facility.

_____ This includes, but is not limited to, diagnostic testing, medication management, and therapy.
initial

_____ I understand that **CNP** provides mobile medical services, and care may be rendered at my
initial residence or assisted living facility. I consent to medical evaluation and treatment in a non-traditional, mobile setting.

_____ I understand, acknowledge, and consent that **CNP's** non-traditional mobile healthcare
initial delivery model may limit certain diagnostics or lab capabilities.

_____ I understand, acknowledge, and consent to the use of photo ID or Facial Recognition
initial software used for identifying patients in mobile apps or tablets.

_____ I understand, acknowledge, and consent that I may be seen and treated by **CNP** in semi-
initial private or common areas.

_____ I authorize **CNP** and its providers and staff to access my residence within the assisted living
initial facility to provide treatment, as necessary.

_____ In the event of a medical emergency, **CNP** providers and staff will alert facility personnel
initial and/or call 911, as appropriate. Our mobile practice does not offer emergency services.

Signature: _____ **Date:** _____
(Patient or Legal Representative)

5. TELEHEALTH CONSENT (if applicable)

I consent to receive healthcare services via telemedicine, when clinically appropriate. I understand that:

_____ I have the right to refuse telehealth care.
initial

_____ My privacy will be protected in accordance with HIPAA.
initial

_____ I acknowledge and consent that I may receive services via a tablet or mobile device provided
initial by **CNP** or my assisted living facility.

_____ I understand, acknowledge, and consent to the use of photo ID or Facial Recognition
initial software used for identifying patients in mobile apps or tablets.

Signature: _____ **Date:** _____
(Patient or Legal Representative)

6. FINANCIAL AGREEMENT

I, _____, acknowledge that:
(Patient Full Name)

_____ I am responsible for any applicable co-pays, coinsurance, deductibles, or uncovered services.
initial

_____ Payment is due upon receipt of billing statement unless other arrangements are made.
initial

Signature: _____ **Date:** _____
(Patient or Legal Representative)

7. PSYCHIATRIC MEDICATION CONSENT

I authorize the prescribing and administration of psychiatric medications if clinically necessary and acknowledge that I have been informed of potential benefits and side effects.

Signature: _____ **Date:** _____
(Patient or Legal Representative)

8. LEGAL GUARDIAN OR MEDICAL POWER OF ATTORNEY

(To be completed if patient lacks decision-making capacity.)

I certify that I am the legal guardian or holder of the Medical Power of Attorney or Statutory Durable Power of Attorney authorized to make medical decisions for or on behalf of _____.
(Patient Full Name)

Guardian/POA Name: _____

Relationship: _____ Phone Number: _(____)____-_____

Signature: _____ **Date:** _____
(Guardian/POA)

Optional Attachments:

Copy of Medicare/Medicaid card

Copy of Guardian or POA documentation

Medication list from facility

Advance Directives (if any)

CLARITY NEUROLOGY AND PSYCHIATRY, LLC

CONSENT TO TREATMENT

Consent to Treatment. I hereby consent to receive medical treatment at Clarity Neurology and Psychiatry LLC ("Clarity Neurology and Psychiatry"), which may include services provided by Clarity Neurology and Psychiatry, employed and/or contracted providers (collectively "Provider(s)"). My signature below hereby affirms my consent for Clarity Neurology and Psychiatry and its Providers to provide health care treatment services to me based on the professional judgment of the Provider rendering services to me, and includes, without limitation consent for me to be evaluated and treated for medical conditions, including physical or mental health conditions and other sensitive matters, as may be deemed necessary or advisable in the judgment of my Provider. I understand that I have the right to refuse any procedure or treatment, and to discuss all medical treatments with my Provider. I further understand that such services may be rendered by an Advanced Practice Registered Nurse ("APRN") or a Physician Assistant ("PA"). However, I understand that I have the ability to choose my provider and Clarity Neurology and Psychiatry will strive to provide services through my preferred provider.

Treatment Services & Risks. I understand that the rendering of medical care is not an exact science and no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments, or other healthcare services provided or recommended to me by Clarity Neurology and Psychiatry or its Providers. Treatment services provided to me hereunder may consist of, without limitation, physical exams, neurological exams, counseling, evaluations, assessments, labs, imaging, and the diagnosis and treatment of health care conditions. This may also include the administration or prescribing of medications. If a particular treatment or service is recommended to me that carries significant risks or has requirements not included herein, I may be asked to provide additional consent for such services.

Consent to the Disclosure of Health Information. To facilitate the treatment services provided to me pursuant to this consent and to coordinate care, I hereby authorize and request that copies of my medical/health records be provided to Clarity Neurology and Psychiatry and authorize Clarity Neurology and Psychiatry to disclose my health information with other outside health care providers providing treatment services to me. I understand that Clarity Neurology and Psychiatry, its business associates, any Provider and/or my insurance company may obtain, use and/or disclose my health information for the purposes of treatment, payment and normal health care operations. This includes without limitation, all medical records, complete plans of treatment, progress summaries, treatment notes, including without limitation mental health information and diagnosis, HIV/AIDS and/or other STD information, substance use or abuse information, genetic information, and any other appropriately related documents or information reasonably requested to facilitate providing treatment to me.

Consent to Mobile Medical Services. I hereby consent to receive medical evaluation and treatment, including neurological and psychiatric care, by clinicians of Clarity Neurology and Psychiatry. This includes, but is not limited to, diagnostic testing, medication management, and therapy. I consent to medical evaluation and treatment in a non-traditional, mobile setting. I understand, acknowledge, and consent that Clarity Neurology and Psychiatry's mobile healthcare delivery model may limit certain diagnostics or lab capabilities.

I understand services may be provided on-site at my assisted living facility. I understand that Clarity Neurology and Psychiatry provides mobile medical services, and care may be rendered at my residence or assisted living facility. I authorize Clarity Neurology and Psychiatry and its staff to access my residence within the assisted living facility to provide treatment, as necessary. I understand, acknowledge, and consent that I may be seen and treated by Clarity Neurology and Psychiatry in semi-private or common areas.

Consent to Telehealth Services. I consent to receive healthcare services via telemedicine, when clinically appropriate. I understand that I have the right to refuse telehealth care. I understand that my privacy will be protected in accordance with HIPAA. I acknowledge and consent that I may receive services via a tablet or mobile device provided by Clarity Neurology and Psychiatry or my assisted living facility. I understand, acknowledge, and consent to the use of photo ID or Facial Recognition software used for identifying patients in mobile apps or tablets.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE REVIEWED THE ABOVE, HAD AN OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED BY CLARITY NEUROLOGY AND PSYCHIATRY, AND THAT I AM VOLUNTARILY CONSENTING TO SERVICES TO BE RENDERED TO THE PATIENT (IDENTIFIED BELOW) BY CLARITY NEUROLOGY AND PSYCHIATRY AND ITS PROVIDERS.

This document is effective for one year from the date of signature below.

PRINTED NAME: _____

RELATIONSHIP TO PATIENT (if not patient): _____

SIGNATURE: _____ **DATE:** _____

CLARITY NEUROLOGY AND PSYCHIATRY LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Clarity Neurology and Psychiatry LLC (referred to as “Clarity Neurology and Psychiatry,” “we,” or “us”) is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information, provide you with this Notice of our legal duties and the privacy practices that we maintain concerning your health information, and to notify you of a breach of your unsecured health information. We are required to follow the terms of this Notice that are in effect at the time.

Applicability and Changes to this Notice. The terms of this Notice apply to all records containing your health information that are created or retained by us. This Notice will be followed by all our health care professionals, employees, medical staff, and other individuals providing services at Clarity Neurology and Psychiatry. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all medical records that we have created or maintained in the past, and for any records that we may create or maintain in the future. We will post a current copy of this Notice on our website. You may also request a copy of the current Notice at any time by reaching out to us at the contact information provided at the end of this Notice.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Right to Inspection and Copies. You have the right to get an electronic or paper copy of your medical records, billing records, and other records maintained by us that are used to make decisions about you. This right does not include psychotherapy notes or health information that is not part of your designated record set. To obtain copies, request inspection of your health information, or request that we send such records to a third party, you must submit your request in writing to Clarity Neurology and Psychiatry’s Privacy Officer, whose contact information is included at the end of this Notice. We may charge a reasonable fee that will be in compliance with applicable law. We may deny your request in limited circumstances. If your request is denied, in some instances, you may request a review of our denial. Another licensed health care professional chosen by us will conduct such reviews and we will follow their findings.

Right to Request an Amendment. You can ask us to correct the health information we maintain about you if you believe it is incorrect or incomplete. To request an amendment, your request must be made in writing and submitted to the Clarity Neurology and Psychiatry Privacy Officer or Administrator. Please provide us with a reason for your request and identify the records you would like amended. If we agree to your request, we will notify you and amend your health information. Please note that we cannot completely delete information contained in your record and the change requested by you will appear as an addendum to the existing record. In certain circumstances, we may deny your request. If your request is denied, we will inform you in writing and explain your rights.

Right to an Accounting of Disclosures. You can ask for a list (an accounting) of the times we shared your health information for six years prior to the date of your request, who we shared it with, and why. Please note the accounting will not include disclosures made regarding treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months. To request an accounting disclosure, submit your request in writing to the Privacy Officer or Administrator listed below.

Right to Request Restrictions. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If we agree to your request, our agreement will be in writing, and we will comply with the restriction unless the information is needed to provide you with emergency care or we are required or permitted by law to disclose it. If you pay in full for a service or health care item out-of-pocket, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to this request unless a law requires us to share that information.

Right to Confidential Communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will agree to all reasonable requests. To request confidential communications, you must make a written request to our Privacy Officer specifying the requested method of contact for billing purposes, or the location where you wish to be contacted. You do not need to give a reason for your request.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of this Notice at any time, even if you agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer or Administrator. All complaints must be submitted in writing to the Privacy Officer at the contact information provided at the end of this Notice. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

Right to a Personal Representative. If you have given someone the legal authority to exercise your rights and choices covered by this Notice, we will honor such requests once we verify their authority. This Notice also applies to minors, disabled adults, or others that are not able to make health care decisions for themselves or who choose to designate someone to act on their behalf. Personal Representatives (including parents of minors and legal guardians) can exercise the rights described in this Notice. There are, however, some situations under State Law where prior authorization of a minor patient is required before certain actions can be taken. We comply with applicable State Laws in this regard.

YOUR CHOICES

In some instances, you can decide what health information we share and with whom we share the information.

Family Members & Friends. We may disclose your health information to individuals who you have chosen to involve in your medical care unless you object to such a disclosure. If you are not able/available to tell us your preference for disclosing your health information with others involved in your care, we may go ahead and share the information if we believe in our professional judgment

that it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Disaster Relief. In the event of a disaster, we may disclose your health information to organizations assisting in disaster relief efforts unless you tell us not to and that decision will not interfere with our ability to respond in emergency circumstances.

Disclosures Requiring Your Authorization. Other uses and disclosures that are not identified by this Notice will be made only with your written authorization. We will never sell or use your health information for marketing purposes without your authorization. Most uses and disclosures of psychotherapy notes require your prior authorization. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time by notifying us in writing. After you revoke your authorization, we will no longer use or disclose your health information based on the authorization. However, uses and disclosures made before we received your withdrawal will not be affected as we cannot take back any disclosures that have already been made based on your authorization. We will never share any substance abuse treatment records without your written permission.

Fundraising. We may contact you for fundraising efforts, but you will be given an opportunity to opt-out of further fundraising communications.

PERMISSIBLE USES & DISCLOSURES

We may use or share your health information in the following ways, in paper or electronic format, without your prior authorization. We will implement safeguards to protect your information when using or disclosing it in these ways.

Treatment. We may use your health information as needed to provide you with treatment. For example, we may use and disclose your health information to order laboratory tests or prescriptions, to assist other health care providers in their treatment of you, or to inform you of potential treatment alternatives or programs. We have implemented reasonable safeguards to protect your health information when receiving treatment at our offices. However, while special care is taken to maintain patient privacy and prevent disclosures of your health information in treatment areas where other patients may be present, some patient information may be incidentally overheard by others while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer and your health care provider.

Payment. We may use and disclose your health information to bill and collect payment for the services and items provided by us. For example, we may share your health information with your health insurance plan so it will pay for the services provided to you. We may also share your health information with other health care providers to assist in their billing and collection efforts.

Health Care Operations. We may use and disclose your health information to operate our practice, improve your care, and contact you when necessary. For example, we may use or disclose your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities. In some circumstances, we may also share health information with other health care providers for their health care operations.

Business Associates. There are some services provided to our organization through contracts with vendors (or "Business Associates"). Examples include an Electronic Medical Record (EMR) system, billing company, or legal services. When these services are contracted, we may disclose your health

information to our Business Associates so that they can perform the job we've asked them to do. To protect your health information, we require each Business Associate to agree in writing to safeguard your health information.

Health Information Exchanges. We may participate in one or more Health Information Exchanges ("HIE"). HIEs allow health care entities participating in the same HIE to quickly share health information as necessary to support timely care coordination and quality health care. For example, your health information related to a recent hospital visit may be shared via HIE with us so that we can promptly coordinate necessary follow-up treatment with you. If we participate in an HIE, we will follow applicable state law related to consent and/or opt-out requirements.

Research. We can use or share your information for research purposes. However, if we participate in research, we must meet many conditions in the law before we can share your information for research purposes. For example, we must ensure your identity is protected or obtain prior authorization from you.

OTHER USES & DISCLOSURES

Public Health & Safety. Subject to certain conditions, we can share your health information for the following purposes:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

Compliance with Law. We will share your health information if state or federal laws require it, including with the Department of Health and Human Services for the purpose of confirming our compliance with federal privacy laws.

Organ & Tissue Donation Requests. We can share your health information with organ procurement organizations.

Medical Examiners and Funeral Directors. We can share health information with a coroner, medical examiner, or funeral director in the event of death.

Workers' Compensation. We may release your health information for workers' compensation and similar programs subject to the requirements of State Law.

Law Enforcement & Other Government Requests. We may share health information for law enforcement purposes or with law enforcement officials when permitted by law. We may also share health information with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

Court Orders and Subpoenas. We can share your health information in response to a court or administrative order, or in response to a subpoena. We will comply with applicable State Laws when certain information is afforded additional protections.

Unsecured Electronic Communications. Clarity Neurology and Psychiatry LLC takes steps to ensure information in paper and electronic form is protected from unauthorized disclosures in accordance with privacy laws when using and disclosing health information as described in this

Notice. However, using any unsecure electronic communication (such as regular email) to communicate with us can present risks to the security of information. These risks include possible interception of the information by unauthorized parties, misdirected emails, shared accounts, message forwarding, or storage of the information on unsecured platforms and/or devices. We do not advise communicating with us via unsecured email or text message or other unsecured electronic means. By choosing to correspond with us via unsecure electronic communication platforms, you are acknowledging and accepting these risks. If you choose to contact us via text messaging or standard email, we may respond to you in the same manner or choose to refrain from text messaging with you, or otherwise limit the information included if we are not able to verify your identity. Additionally, you should understand that use of email, text messaging, and/or any other form of electronic communications is not intended to be a substitute for professional medical advice, diagnosis, or treatment and should never be used in a medical emergency.

HIPAA Considerations Unique to Mobile Medicine. Because Clarity Neurology and Psychiatry provides care utilizing a non-traditional mobile delivery methodology, medical records and related equipment may be transported by secure means to and from the location of care, and all reasonable safeguards will be used to protect your information in full compliance with HIPAA and other applicable privacy statutes regulations.

Questions & Concerns. If you have questions or would like additional information, you may contact our Practice's Privacy Officer at the below contact. If you believe that your privacy rights have not been followed as directed by applicable law or as explained in this Notice, you may file a complaint with us. Please send any complaint to the Privacy Officer listed below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, and you will not be penalized by us for filing such a complaint.

Attn: Privacy Officer Kaitlan Pham
Clarity Neurology and Psychiatry LLC
606 South 11th Street
Richmond, Texas 77469
Phone: 346-330-2672
Fax: 346-528-2672
Email: kaitlan@cnpicare.com

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTAND, AND ACCEPT THE CLARITY NEUROLOGY AND PSYCHIATRY, LLC NOTICE OF PRIVACY PRACTICES AND THAT YOU HAVE HAD AN OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED COMPLETELY.

PRINTED NAME: _____

RELATIONSHIP TO PATIENT (if not patient): _____

SIGNATURE: _____ **DATE:** _____

CLARITY NEUROLOGY AND PSYCHIATRY LLC

FINANCIAL RESPONSIBILITY & BILLING POLICY

Insurance: We participate in several insurance plans, including Medicare and Medicaid. If you are not insured by a health plan we do business with, payment in full is expected at each visit. Upon request, a schedule of our standard fees will be provided. We will make every effort to verify your coverage prior to your first appointment. However, the more information we can get from you, the less likely you are to receive a bill from us in error. We will provide you with your cost-sharing obligations related to specific services. You are responsible for notifying Clarity Neurology and Psychiatry LLC if any services are related to work injuries or accident, and that you may be billed for services if you do not provide the information to Clarity Neurology and Psychiatry LLC about workers compensation or other insurance that may apply.

Co-payments, Deductibles & Coverage Changes: All co-payments, coinsurance, and deductibles must be paid no later than 30 days after a statement is received. This arrangement is part of your contract with your insurance company, and we are required to collect co-payments, coinsurance, and deductibles. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you are covered by Medicare, Medicare will send you an Explanation of Benefits (EOB), which outlines what services were billed, what services were covered, and how much the patient may owe, if anything.

Non-covered services: Please be aware that some of the services you receive may not be covered by Medicare or other insurers. Services that are not covered by your insurance are the responsibility of the patient. If you are a self-pay or uninsured patient, a good faith estimate is available, in writing or electronically, for the total expected costs of any health care items or services, upon request, when scheduling such items and services.

Services by other Providers: We rely on a network of other providers to provide complete patient care, this may include labs, radiology facilities and other specialists. In cases where we either do not participate with your insurance or accept self-pay status for a patient, referrals to other providers are not covered, either. If a referral or order is deemed necessary, we will make every effort to communicate this to you ahead of time so you may contact your insurance to find out what possible covered alternatives exist. However, we are not responsible for balances resulting from treatment you receive from other providers.

Proof of insurance: All patients must complete our patient information form before seeing the provider(s). We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission/Assignment of Claims: We will document the services rendered will submit claims to your insurance carrier, including Medicare and/or Medicaid, as applicable, and assist you in any way that we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. By signing below, you authorize direct payment of medical benefits to Clarity Neurology and Psychiatry LLC for services rendered by Clarity Neurology and Psychiatry LLC and its providers. You also authorize the use and disclosure of your protected health information as needed to facilitate payment for health care services rendered. If you do not consent to release of this information, Clarity Neurology and Psychiatry LLC will be unable to bill your insurance company and you will be responsible for any services rendered.

Unpaid Balances/ Late Fees: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated and your account may be referred to collections if it remains unpaid. Clarity Neurology and Psychiatry is entitled to collection fees to the extent permitted by law. We encourage you to contact our office to discuss a payment plan if you are unable to pay your balance due to financial hardship. Any returned checks will result in a \$25 service charge. You will also be required to issue future payments in the form of cash or credit card.

Missed appointments: If you do not notify us that you are unable to attend your appointment at least 24 hours in advance, we may charge you a fee for missing your appointment. These charges will be your responsibility. Please help us to serve you better by keeping your regularly scheduled appointments and by providing at least 24-hour advance notice if you will not be able to attend.

Termination of Relationship. Please be aware that if a balance remains unpaid or other circumstances arise where we do not believe that continuing a treatment relationship will be beneficial, we may terminate our treatment relationship with you. If we terminate our treatment relationship with you, you will be notified in advance by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, we will continue to be available to you as needed to provide a continuity of care and to ensure you are able to find a new provider.

Assignment of Benefits. I hereby authorize direct payment of medical benefits to Clarity Neurology and Psychiatry LLC for services rendered by Clarity Neurology and Psychiatry and its providers. I understand that I am financially responsible for any balance not covered by my insurance in accordance with Clarity Neurology and Psychiatry LLC's financial policies. I request that payment of authorized benefits be made on my behalf to Clarity Neurology and Psychiatry and authorize the use and disclosure of my health information as needed to facilitate payment for the health care services I receive. I understand that if I do not consent to release of information for payment purposes, Clarity Neurology and Psychiatry and my Provider will be unable to bill my insurance company or other party responsible for payment for the services at issue, and I may be billed directly for these services.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines. By signing below, I hereby authorize Clarity Neurology and Psychiatry LLC to submit claims directly to Medicare or Medicaid for services rendered in my residence or assisted living facility, and I acknowledge that the location of service may be different from a traditional clinical setting.

PRINTED NAME: _____

RELATIONSHIP TO PATIENT (if not patient): _____

SIGNATURE: _____ **DATE:** _____

CLARITY NEUROLOGY AND PSYCHIATRY LLC

TELEHEALTH CONSENT

Telehealth is the delivery of health care services when the health care provider and the undersigned patient (the "Patient") are not in the same physical location and communicate through the use of telecommunications technology. Telehealth may be used for Patient evaluation, diagnosis, consultation, monitoring, and/or treatment, including issuance of certain medication orders or prescriptions. The Patient understands and agrees to the following with respect to telehealth:

1. By signing this consent form, the Patient agrees to receive health care services via telehealth from a CLARITY NEUROLOGY AND PSYCHIATRY LLC ("Clarity Neurology and Psychiatry") provider (the "Provider"). The Patient understands that he or she must be physically located in the State of Texas during his or her telehealth consultation/visit and represents that the Patient will remain physically located in the State of Texas during the entirety of his or her telehealth consultation/visit.
2. The Patient understands that telehealth may not be appropriate in all cases and has certain limitations. If the Provider determines that information transmitted via telehealth is insufficient to allow for appropriate medical decision-making, the Provider may decline to proceed with diagnosis and/or treatment. Certain health conditions or assessments may require an in-person exam, in which case the Provider may refer the Patient to other health care providers or direct the Patient to see his or her primary care physician or specialist. If physical test(s) are indicated, the tests may be conducted by individual(s) at the Patient's location, or at a testing facility, at the direction of the Provider. By signing below, the Patient is electing to have a telehealth visit instead of an in-office visit at Clarity Neurology and Psychiatry.
3. The Patient understands that Clarity Neurology and Psychiatry will generate a medical record in which the telehealth consultation/visit will be documented and maintained in accordance with laws that protect privacy and confidentiality of health information. The Patient may contact Clarity Neurology and Psychiatry to request a copy of his or her medical record.
4. The Patient will not create an audio or video recording of the telehealth consultation/visit without the prior written consent of the Provider.
5. The Patient understands that telehealth involves the electronic communication and/or transmittal of the Patient's private health information (PHI). The Patient's PHI includes, but is not limited to, the Patient's identifying information; medical history; diagnoses; communications to and from the Patient's other health care providers; assessments; evaluations; imaging; and may contain sensitive information (HIV/AIDS status, substance use and abuse history, genetic information, etc.). While Clarity Neurology and Psychiatry utilizes a secure telehealth platform, the Patient understands that PHI may be lost due to technical failures, cyber intrusion, or other issues disrupting the Patient's telehealth consultation/visit or causing delays in response from Clarity Neurology and Psychiatry. The Patient assumes these risks and holds Clarity Neurology and Psychiatry and its providers harmless from any claims arising out of the use of telehealth to conduct the visit. The Patient understands that PHI obtained during the visit will not be disclosed to others without the Patient's consent, unless permitted by applicable law and in accordance with Clarity Neurology and Psychiatry's Notice of Privacy Practices. Patient has the right to request that Clarity Neurology and Psychiatry submit information about his or her treatment with the Patient's primary care physician. If the Patient makes

such request and consents to such disclosure of PHI, Clarity Neurology and Psychiatry will send the Patient's medical record, and/or a report containing an explanation of the Patient's treatment, to the Patient's primary care provider within 72 hours of their consultation/visit with provider.

6. If the Patient utilizes telehealth in places or on devices where other individuals may be able to access, intercept, or overhear the information, the Patient understands that the confidentiality of the telehealth consultation/visit may be compromised.

7. The Patient understands that other individual(s) may be present with the Provider during the telehealth consultation/visit to operate the video equipment or for other purposes. These individuals have agreed to maintain the confidentiality of the information obtained. The Patient will be informed of the presence of any such individual and will have the right to request the following: (a) leave out specific details of the Patient's medical history/physical examination; (b) ask non-medical personnel to leave the room; and/or (c) terminate the telehealth consultation/visit at any time.

8. The Patient understands that Clarity Neurology and Psychiatry providers may prescribe medically appropriate medication to the Patient specifically to treat the Patient's diagnosed condition, but there is no guarantee that the Patient will be prescribed medication, and state and federal law restrict the prescription of certain medications through telehealth. If medication is prescribed, the Patient, at all times, has the ability to request that his or her medication be filled at the pharmacy provider of the Patient's choice.

9. The Patient understands that delays in medical evaluation or treatment may occur due to deficiencies or failures of the telehealth equipment. In the event of an emergency or a situation in which the Patient could reasonably expect to develop into an emergency, the Patient agrees to call 911 or the nearest emergency room and follow the directions of emergency personnel.

10. The Patient understands that certain insurances will not reimburse for telehealth services, and the Patient agrees to bear the financial responsibility for the cost of the telehealth consultation/visit in the event their insurance does not cover such services.

11. The Patient certifies that the Patient is at least 18 years of age and otherwise legally competent to make decisions about his or her own health care.

12. The Patient understands and agrees that this Telehealth Consent will remain in effect and be valid from the date executed below until revoked, in writing, by the Patient or by another authorized person.

13. The Patient has had an opportunity to review Clarity Neurology and Psychiatry's provider's credentials and selected their preference for provider.

14. The Patient understands there are alternatives to telehealth, such as an in-person encounter, as they have been explained, and in choosing to participated in a telehealth consultation/visit, understand that some parts of the exam may require physical testing to be performed at another location at the direction of Clarity Neurology and Psychiatry.

15. The Patient has been advised of all the potential risks, consequences, and benefits of telehealth. The Patient has also been afforded the opportunity to ask questions about the information presented on this form. All Patient questions have been answered, and he or she understands the information contained herein.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, THAT YOU HAVE HAD AN OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED, AND THAT YOU ARE VOLUNTARILY CONSENTING TO TELEHEALTH SERVICES TO BE RENDERED BY CLARITY NEUROLOGY AND PSYCHIATRY.

PRINTED NAME: _____

RELATIONSHIP TO PATIENT (if not patient): _____

SIGNATURE: _____ **DATE:** _____

CLARITY NEUROLOGY AND PSYCHIATRY LLC

CONSENT FOR USE OF CELL PHONE AND TEXT MESSAGING

I authorize Clarity Neurology and Psychiatry LLC and its staff to contact me via telephone call, voicemail, or text message at the phone number(s) I have provided for purposes related to my healthcare, including:

- Appointment reminders
- Scheduling and follow-up
- Medication and treatment instructions
- Billing and insurance information
- Other non-emergency healthcare-related communication

I understand that:

- Text messages and voicemail may not be encrypted or secure.
- There is a risk that messages could be intercepted or read by unauthorized parties.
- I may opt out of these communications at any time by notifying Clarity Neurology and Psychiatry LLC in writing.

☐ I consent to receive calls and text messages as described above.

☐ I do NOT consent to receive calls and text messages. Please use other means to contact me.

By signing below, you acknowledge and agree for Clarity Neurology and Psychiatry LLC to contact you at the phone number(s) listed below. You acknowledge and agree that Clarity Neurology and Psychiatry LLC can discuss the following over the phone: medical diagnosis and assessment/evaluation results, mental health information and diagnosis, HIV/AIDS and/or other STD information, substance use or abuse information, genetic information, and any other appropriately related documents or information reasonably requested to facilitate providing treatment to me. Clarity Neurology and Psychiatry LLC's staff will attempt to verify that the receiver of the phone call is you based on its policies and procedures regarding privacy. Voicemails or other messages will be limited to caller's identity, practice's name, and information for a call back. You may change your contact preferences at any time by notifying our staff. You understand that there are inherent risks involved in having providers and staff leave messages on your voicemail, especially if such voicemail can be accessed by others. Such risks include misdirected messages, interception by others, or inadvertent disclosures to others who have access to your phone or voicemail. By signing below you are accepting all such or similar risks.

I would like to communicate via:

☐ Cell Phone: _() - _____ Carrier: _____

____ I agree to staff leaving a voicemail message.

initial

____ I agree to receiving text messages.

initial

☐ House Landline: _() - _____

____ I agree to staff leaving a voicemail message.

initial

Please provide the following information:

Patient name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ ST: _____ ZIP: _____

Please initial each blank above and sign below:

PRINTED NAME: _____

RELATIONSHIP TO PATIENT (if not patient): _____

SIGNATURE: _____ **DATE:** _____



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____

Address _____

City _____ State TX Zip Code 77040

Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Clarity Neurology and Psychiatry, LLC

Address 12934 Bellaire Blvd, Suite 208

City Houston State TX Zip Code 77072

Phone (346) 200-5909 Fax (346) 200-5660

REASON FOR DISCLOSURE (Choose only one option below)

- ☒ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- | | | | |
|--|--|---|---|
| ☒ All health information | ☐ History/Physical Exam | ☐ Past/Present Medications | ☐ Lab Results |
| ☐ Physician's Orders | ☐ Patient Allergies | ☐ Operation Reports | ☐ Consultation Reports |
| ☐ Progress Notes | ☐ Discharge Summary | ☐ Diagnostic Test Reports | ☐ EKG/Cardiology Reports |
| ☐ Pathology Reports | ☐ Billing Information | ☐ Radiology Reports & Images | ☐ Other _____ |

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____

Signature of Individual or Individual's Legally Authorized Representative

DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____

Signature of Minor Individual

DATE

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §§ 181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).

Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

CONSENT FOR TREATMENT & AUTHORIZATION TO USE / DISCLOSE MENTAL HEALTH INFORMATION

PATIENT INFORMATION

Patient Name:	
Date of Birth:	
Facility/Location (if applicable):	
Responsible Party/Legal Guardian (if applicable):	

SECTION 1: CONSENT TO TREAT

I voluntarily consent to mental health evaluation and treatment by the providers at _____, which may include psychiatric, neurological, psychological, or counseling services. I understand that treatment may be provided at an assisted living facility, mobile clinic, or via telehealth. I authorize providers to discuss treatment plans, medications, and mental health diagnoses with me (or my authorized representative) for the purpose of care and coordination.

SECTION 2: AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION

(Required under Texas Health & Safety Code § 611)

I authorize _____ to release my mental health information to the following provider(s) for treatment purposes:

Clarity Neurology and Psychiatry, LLC
12934 Bellaire Blvd, Suite 208
Houston, TX 77072
(346) 200-5909
(346) 200-5660 Fax
NPI: 1043016520

Type of Information Authorized for Disclosure (check all that apply):

- ☐ Psychiatric diagnosis
- ☐ Medication/treatment history
- ☐ Psychological/neurological testing
- ☐ Progress notes
- ☐ Psychotherapy notes (requires separate specific authorization)
- ☐ Other (describe): _____

SECTION 3: SPECIFIC AUTHORIZATION FOR PSYCHOTHERAPY NOTES

☐ I authorize the release of psychotherapy notes (notes kept separate from the medical record by my therapist and used solely for personal use by the provider).

I authorize the use or disclosure of the following psychotherapy notes:

☐ Entire content of psychotherapy notes

☐ Specific session(s) dated: _____

☐ Other (specify): _____

SECTION 4: RESTRICTIONS & REDISCLOSURE

I understand that:

- This information may not be redisclosed by the recipient unless I specifically authorize it.
- Redisclosure without consent is prohibited under Texas Health & Safety Code § 611.006.
- I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on it.
- This consent will expire:
 - ☐ On this date: ____/____/_____
 - ☐ After this event: _____
 - ☐ 1 year from the date of signing (default if left blank)

SECTION 5: PATIENT RIGHTS

I understand that I have the right to:

- Refuse to sign this authorization (which will not affect my ability to receive treatment unless disclosure is required for that treatment).
- Receive a copy of this signed form.
- Request access to and amendments of my records.
- File a complaint with the clinic or U.S. Department of Health and Human Services if I believe my privacy rights have been violated.

SIGNATURES

Signature of Patient or Legal Representative: _____ Date: _____

(Print name of representative and legal authority, if applicable): _____

Witness (optional): _____

Clinic Use Only

Form received and reviewed by: _____ Date: _____

☐ Copy provided to patient/representative

CLARITY NEUROLOGY AND PSYCHIATRY LLC

PATIENT RIGHTS AND RESPONSIBILITIES

Welcome to Clarity Neurology and Psychiatry LLC ("Clarity Neurology and Psychiatry"). While receiving medical care from Clarity Neurology and Psychiatry, it is important to us that you know that Clarity Neurology and Psychiatry will recognize your rights while you are receiving care and asks that you respect your Clarity Neurology and Psychiatry health care provider's right to expect certain behavior on the part of its patients and clients. You may request a copy, at any time, of the full text of the applicable law (§ 381.026, F.S.) that applies to the rights and responsibilities described herein from Clarity Neurology and Psychiatry. Below is a summary of your rights and responsibilities when you receive care.

Patient Rights. When you/your child receive services from Clarity Neurology and Psychiatry, you/your child have the right:

- To be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- To a prompt and reasonable response to questions and requests.
- To know who provides medical services and who is responsible for his or her care.
- To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- To bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.
- To know what rules and regulations apply to his or her conduct.
- To be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- To refuse any treatment, except as otherwise provided by law.
- To be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- To receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- To know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- To express grievances regarding any violation of his or her rights, as stated in Texas law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

Patient Responsibilities. When you receive services from Clarity Neurology and Psychiatry LLC, you have the responsibility:

- To provide Clarity Neurology and Psychiatry, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- To report unexpected changes in your condition to Clarity Neurology and Psychiatry.
- To report to the health care provider whether you comprehend a contemplated course of action and what is expected of you.

- To follow the treatment plan recommended by Clarity Neurology and Psychiatry.
- To keep appointments and, when you are unable to do so for any reason, to notify Clarity Neurology and Psychiatry.
- To act responsibly for your actions if you refuse treatment or do not follow Clarity Neurology and Psychiatry's instructions.
- To ensure that the financial obligations of your health care are fulfilled as promptly as possible.
- To follow Clarity Neurology and Psychiatry rules and regulations affecting patient care and conduct.

Patient's Rights Policy & Notice of Privacy Policy Receipt

By signing below, you acknowledge that you have read and understand the Clarity Neurology and Psychiatry LLC's Patient Rights & Responsibilities and that you have been provided with a copy of the Clarity Neurology and Psychiatry LLC's Notice of Privacy Practices. Clarity Neurology and Psychiatry LLC is dedicated to maintaining the privacy and security of information in accordance with applicable law. More information regarding privacy and security practices at Clarity Neurology and Psychiatry LLC is detailed in the Notice of Privacy Practices.

PRINTED NAME: _____

RELATIONSHIP TO PATIENT (if not patient): _____

SIGNATURE: _____ **DATE:** _____

CLARITY NEUROLOGY AND PSYCHIATRY LLC

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Clarity Neurology and Psychiatry LLC (“Clarity Neurology and Psychiatry”) complies with applicable Federal civil rights laws, including Title VI, Section 504, Title IX, and the Age Act and Section 1557 of the Affordable Care Act, and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). Our practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Clarity Neurology and Psychiatry provides at no cost reasonable modifications, appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters, and written information in other formats (i.e., braille, large print, audio, accessible electronic formats, other formats) in a timely manner, when such modifications or aids and services are necessary to ensure accessibility and equal opportunity to participate to individuals with disabilities. Clarity Neurology and Psychiatry LLC also provides language assistance services at no cost to people whose primary language is not English, including qualified interpreters and information in electronic or written in different languages or oral translation. If you need these services, please let the front desk or any staff member know of your needs and such services will be provided in a timely manner.

If you believe Clarity Neurology and Psychiatry has failed to provide these services or discriminated against you in another way on the basis of race, color, national origin, age, disability, sex, or religion, you can file a grievance with our Civil Rights Coordinator: **Kaitlan Pham at 346-330-2672; kaitlan@cnpicare.com.**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to assist you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf> , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (fax)
1-800-537-7697 (Toll Free).

Complaint forms are available at:

<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

French Creole (Haitian Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Kaitlan Pham at 1-346-330-2672; kaitlan@cnpicare.com.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

Arabic: لصتا ناج\$اب كل رفاوتت ةيوغلا ةدعاس\$ا تامدخ ناف ،ةغلا ركذا ثدحتت تنك اذا :ةظوحلم مقرب . Kaitlan Pham at 1-346-330-2672; kaitlan@cnpicare.com.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

Korean: 주의: 한국어로 대화할 때는 무료로 언어 지원 서비스를 이용하실 수 있습니다. Kaitlan Pham at 1-346-330-2672; kaitlan@cnpicare.com

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer Kaitlan Pham. at 1-346-330-2672; kaitlan@cnpicare.com.

Thai: !ยน: \$า&ณ(ดภาษาไทย&ณสามารถใ้บ5การ7วยเห;อทางภาษา!>ฟ! โท Kaitlan Pham at 1-346-330-2672; kaitlan@cnpicare.com.

Opting Out of Notice of Non-Discrimination

Clarity Neurology and Psychiatry LLC will provide you with the Notice of Non-Discrimination annually or upon your request, in your primary language and through appropriate auxiliary aids and services. You may opt out of this Notice of Non-Discrimination ("Notice") being provided to you with every significant document by signing below. Your signature below is not a waiver of your right to receive language assistance services or any appropriate auxiliary aid or service, as required by law. A non-response will also not result in you opting out of the Notice. Your opting out of the Notice will be effective for one year from the date of your signature.

PRINTED NAME: _____

RELATIONSHIP TO PATIENT (if not patient): _____

SIGNATURE: _____ **DATE:** _____



HEALTHCONNECT • TX

Patient Authorization for Healthconnect Texas

Clarity Neurology and Psychiatry, LLC is part of Healthconnect Texas (HTX), a secure electronic network that allows doctors, hospitals, labs, pharmacies, and health insurers to safely share your health information. A full list of participants is available at healthconnecttx.org.

How It Works

- When you join Healthconnect, your doctors can securely access your health records from other participating providers.
- This does not change who can see your information—only how it is shared.
- All participants must follow state and federal privacy laws to protect your information.
- Your treatment and benefits will not be affected if you choose not to join.

Your Consent

By signing this authorization, you allow Healthconnect and its participants to share your health records electronically for treatment, payment, and healthcare operations. Healthconnect may also share your information with other secure health networks across Texas and the U.S., following the same privacy protections.

Your Right to Revoke

This authorization stays in effect unless you revoke it in writing at any participating provider's office. However, any information shared before revocation will remain accessible to providers who have already received it.

Patient Name: _____

Signature of Authorized Person: _____ Date: _____

Name (if different from Patient): _____ Relationship to Patient: _____

Initial here if you do NOT want your providers to see your records through Healthconnect. _____