CEREBRAL CARE CONSULTING

CONSENT FOR TREATMENT

SECTION 1: WELCOME TO CEREBRAL CARE CONSULTING

Cerebral Care Consulting, LLC is a physician-led mobile specialty practice focused on geriatric neuropsychiatry, cognitive disorders, behavioral neurology, and the psychiatric care of older adults. Rather than requiring patients to travel to a traditional office, the Practice provides care in assisted living communities, memory care communities, skilled nursing facilities, rehabilitation facilities, and other healthcare settings, as well as through telehealth when clinically appropriate and permitted by law. We provide evaluation, diagnosis, treatment recommendations, medication management, psychotherapy when clinically appropriate, care coordination, and consultation for individuals with conditions affecting memory, thinking, mood, behavior, and neurological function. *Our goal is to deliver thoughtful, evidence-based, patient-centered medical care while working collaboratively with patients, families, caregivers, primary care physicians, advanced practice providers, specialists, therapists, residential facilities, hospitals, hospice agencies, and other healthcare professionals to promote safety, preserve function, and improve quality of life.* **Please read this document carefully. If you have questions about any portion of this agreement, we encourage you to ask before signing.**

SECTION 2: DEFINITIONS

Unless otherwise indicated, the following definitions apply throughout this Agreement.

"Practice" means Cerebral Care Consulting, LLC, including its physicians, nurse practitioners, physician assistants, residents, students, employees, contractors, consultants, and authorized agents.

"Provider" means the physician or other licensed healthcare professional participating in your care.

"Patient" means the individual receiving medical services.

"Authorized Representative" means a person legally authorized to make healthcare decisions on behalf of the patient, including a healthcare agent, durable power of attorney for healthcare, court-appointed conservator, guardian, parent of a minor child, or other legally recognized surrogate decision-maker.

"Protected Health Information" or "PHI" has the meaning assigned under the Health Insurance Portability and Accountability Act ("HIPAA").

"Caregiver" includes family members, friends, facility staff, home health personnel, hospice staff, and other individuals involved in the patient's daily care.

"Medical Record" includes all written, electronic, photographic, audio, video, laboratory, imaging, billing, and communication records generated or maintained by the Practice.

SECTION 3: CONSENT FOR EVALUATION, DIAGNOSIS, AND TREATMENT

3.1 General Consent: I voluntarily request medical care from the Practice. I authorize the Practice to perform those medical evaluations, examinations, diagnostic procedures, consultations, medication management services, and treatments that my Provider determines are medically appropriate based upon my clinical condition. This consent applies to outpatient, facility-based, telehealth, and other medically appropriate encounters unless specifically limited by law.

3.2 Continuing Consent: This consent is intended to remain in effect throughout my treatment with the Practice unless revoked in writing. Withdrawal of consent does not affect services previously provided and does not relieve me of financial responsibility for services already rendered.

3.3 No Guarantee: Medicine is not an exact science. Although the Practice will use reasonable medical judgment and evidence-based standards of care, I understand that no guarantee has been made regarding diagnosis; prognosis; response to treatment; medication effectiveness; recovery; functional improvement; or clinical outcome. Treatment recommendations are based upon information reasonably available at the time services are provided.

3.4 Individualized Medical Judgment: I understand that treatment recommendations are individualized. Recommendations may change over time as new medical information becomes available, my condition changes, additional testing is obtained, or accepted medical standards evolve.

3.5 Informed Decision Making: My Provider has explained or will explain as medically appropriate: my diagnosis or working diagnosis; the purpose of recommended treatment; expected benefits; reasonably foreseeable risks; reasonable alternatives; the risks of declining treatment; and the opportunity to ask questions.

SECTION 4: NOTICE OF PRIVACY PRACTICES

4.1 Creation of Medical Records. Each time our practice visits you, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all the records of your care generated by our practice.

4.2 Legal Requirements. We are required by law to maintain the privacy of your health information, provide you with a description of our privacy practices, and notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

4.3 Permitted Uses and Disclosures. The following categories describe examples of the way we use and disclose health information:

1. For Treatment. We may use health information about you to provide you with treatment or services.
2. For Payment. We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer.
3. Appointment Reminders. To remind you that you have an appointment for medical care.
4. Treatment Alternatives. To tell you about possible treatment alternatives.
5. Health-Related Communications. To tell you about health-related benefits or services.
6. Population Health Activities. For population-based activities relating to improving health or reducing health care costs.
7. Training and Competency Review. For conducting training programs or reviewing the competence of health care professionals.
8. Medicaid Database. To a Medicaid eligibility database, as applicable.
9. Messages. When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail**.**

4.4 Business Associates and Care Collaboration. Some services are provided through contracted business associates. Examples include Spruce Health, RXNT, Elation, Dock Health, Google Workspace, JotForm, Keragon, and QuickBooks. We may share your health information with these entities as needed so they can perform services on our behalf, including billing and administrative functions. Your care may also involve collaboration between this practice and your primary care provider or other treating clinicians. This collaboration is part of your patient-care relationship and is intended to improve care coordination, safety, and medical and nursing treatment. For these purposes, relevant health information may be shared, including through limited shared access to an electronic medical record. All business associates and collaborating providers are required by federal law to protect and safeguard your health information.

4.5 Research and Health Information Communications. The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies, but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study. We may communicate with you via newsletters, mail-outs, or other means regarding treatment options, health-related information, disease-management programs, wellness programs, research projects, or other community-based initiatives or activities in which our practice participates.

4.7 Senior Living Facility Joint Notice. If applicable, our practice is presenting you with this document as a joint notice with your senior living facility. Information will be shared as necessary to carry out treatment, payment, and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment, as it may affect treatment at the time. Protected health information will be made available to your senior living personnel as necessary to carry out treatment, payment, and health care operations.

4.8 Health Information Organizations. Federal and state laws may permit us to participate in organization with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

4.9 Disclosures Required by Law. As permitted or required by law, we may use or disclose protected health information to public health authorities, the Food and Drug Administration, law enforcement, health oversight agencies, correctional institutions, workers' compensation programs, organ and tissue donation organizations, military authorities, coroners and funeral directors, national security or protective service agencies, and other persons or entities authorized to prevent or lessen a serious threat to health or safety. We may also disclose protected health information in connection with judicial or administrative proceedings, including in response to a court order, subpoena,

warrant, or other lawful process. Federal and state laws may require additional reporting or disclosures for public health.

SECTION 5: HEALTH INFORMATION RIGHTS

5.1 Although your health record is the physical property of our practice, you have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our practice. Any request for an amendment must be sent in writing to the practice. We may deny your request for an amendment, and if this occurs, you will be notified of the reason for the denial.

5.2 You have the right to request an accounting of disclosures.

5.3 You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Any request for a restriction must be sent in writing to our practice. We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

5.4 You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by our practice and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

5.5 You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Our practice has a website where you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link. To exercise any of your rights, please obtain the required forms from our practice and submit your request in writing.

5.6 We reserve the right to change this notice, and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted on our website and include the effective date. In addition, each time you register for a visit with our practice, we will offer you a copy of the current notice in effect.

5.7 If you believe your privacy rights have been violated, you may file a complaint with our practice by following the process outlined in the practice's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

5.8 Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

Section 6: PATIENT RIGHTS

6.1 Respectful and Nondiscriminatory Care. Receive considerate, respectful, and compassionate care regardless of race, religion, national origin, sex, age, disability, sexual orientation, gender identity, or source of payment.

6.2 Privacy and Confidentiality. Have your medical records and information kept confidential, in compliance with HIPAA and Tennessee law. You may request access to your records and receive a copy of our Notice of Privacy Practices.

6.3 Information and Communication. Receive clear, accurate information regarding your health status, diagnosis, treatment options, and outcomes in a manner you understand. Interpretation services are available when needed.

6.4 Participation in Care. Take part in decisions about your care, including the right to refuse or request alternative

treatments. You may request a second opinion or change providers.
6.5 Informed Consent. Make informed decisions about care, including being advised of the risks, benefits, and alternatives before consenting to treatments or procedures.
6.6 Access to Care. Receive timely medical care and be informed of provider credentials upon request.
6.7 Billing and Insurance. Be informed in advance about charges and services not covered by insurance. Receive an itemized bill and explanations upon request.
6.8 No Surprise Billing (No Surprises Act). You are protected under federal law from unexpected out-of-network charges in situations where you had no control over the provider choice. This includes emergency services and non-emergency services at in-network facilities where some providers are out-of-network. You are entitled to Good Faith Estimates if you are self-pay or uninsured and can dispute bills $400+ over the estimate. Learn more: https://www.cms.gov/nosurprises
6.9 Concerns and Grievances. You may file complaints about your care, safety, or privacy with no fear of retaliation. Contact our clinic directly or the Tennessee Department of Health Complaint Division at 1-800-852-2187.

SECTION 7: PATIENT RESPONSIBILITIES
7.1 Patient Responsibilities: Safe and effective medical care depends upon accurate information and active participation by the patient and, when appropriate, the patient's legally authorized representative or caregiver. The patient agrees to provide complete and accurate information regarding their medical history, medications, symptoms, living situation, decision-makers, and any other information that may affect medical care. The Practice relies upon this information in making medical decisions. Incomplete or inaccurate information may adversely affect diagnosis, treatment recommendations, medication safety, and clinical outcomes.
7.2 Notify the Practice of Changes: The patient agrees to promptly notify the Practice regarding: hospital admissions; emergency department visits; medication changes made by another provider; new medical diagnoses; new allergies; significant changes in symptoms; changes in residence or facility; changes in legal decision-making authority; changes in insurance coverage; and changes in contact information.
7.3 Caregiver Participation: Because many patients treated by this Practice have disorders affecting memory or judgment, the patient understands that caregiver participation is frequently beneficial and, in some cases, medically necessary. The patient agrees to identify an emergency contact and, when appropriate, a caregiver or legally authorized representative who may assist in communication and treatment planning.
7.4 Respectful Communication: The Practice is committed to maintaining a safe and respectful environment for patients, families, visitors, and staff. Patients, family members, caregivers, and representatives are expected to communicate respectfully with physicians, advanced practice providers, trainees, employees, contractors, facility staff, and other patients. Threatening behavior, intimidation, harassment, discrimination, abusive language, physical violence, or repeated disruptive conduct may result in termination of the physician-patient relationship, subject to applicable law and appropriate continuity of care. Constructive disagreement regarding medical recommendations is expected and does not, by itself, constitute disruptive behavior.
7.5 Financial Responsibility: The patient agrees to remain financially responsible for services rendered as described in the Financial Responsibility section of this Agreement, regardless of insurance coverage, unless otherwise prohibited by law.

SECTION 8: CONSENT FOR TELEHEALTH, COMMUNICATION & TECHNOLOGY
8.1 Telehealth Services: Telehealth is the delivery of healthcare services through electronic communications, including interactive audio, video, telephone, secure text messaging, email, and other data communications. Providers are licensed in the State of Tennessee and provide telehealth services in accordance with Tennessee Code Annotated § 63-1-155 and applicable federal law. By signing this Agreement, I understand and agree that: (1) telehealth services will be provided using appropriate communication technology; (2) the risks, benefits, and limitations of telehealth have been explained; (3) I may refuse or withdraw consent to telehealth at any time without affecting future access to care; (4) I may request in-person care when available and clinically appropriate; (5) telehealth has limitations, including technology failure, privacy risks, and the inability to perform certain physical examinations; (6) I am responsible for maintaining privacy on my end of the communication; (7) if a telehealth connection fails, the provider may use an alternative communication method, including telephone; and **(8) telehealth is not appropriate for medical emergencies, and I will call 911 or go to the nearest emergency department if an emergency occurs.**
8.2 Communication Authorization: By signing this document, I authorize the Practice to communicate with me using technology for scheduling, treatment updates, medication management, and education. Standard message and data rates may apply if using mobile devices. The Practice makes reasonable efforts to review electronic communications

during normal business hours. Messages are generally addressed in the order received according to medical urgency. The Practice does not guarantee same-day responses. Electronic communications received after business hours, on weekends, or on holidays may not be reviewed until the next business day. Patients should never delay emergency medical care while awaiting a response. The patient authorizes the Practice to communicate using the email address and telephone number provided by the patient.

8.3 Digital Health Tools and Artificial Intelligence: I understand that the Practice may utilize secure, FDA-cleared or HIPAA-compliant technologies to aid in the documentation, tracking, or coordination of care. This may include digital health tools, clinical decision-support systems, artificial intelligence algorithms, or electronic prescribing. Tennessee AI Disclosure. In accordance with Tennessee law governing the use of artificial intelligence in healthcare, the practice will inform you if AI-assisted tools are used in clinical decision-making that materially affects your diagnosis or treatment plan. You have the right to request information about the AI tool's purpose and how it was used in your care. The Practice may use ambient listening or speech recognition technology to assist in creating accurate medical documentation. These technologies are used solely to improve documentation efficiency and accuracy. The resulting medical record is reviewed and finalized by the treating Provider before becoming part of the patient's permanent medical record.

8.4 Electronic Medical Records. The practice maintains electronic medical records in compliance with Tennessee Code Annotated § 63-2-101 and all applicable state and federal regulations governing the security, privacy, and accessibility of health information. Electronic health records are maintained on secure, encrypted systems and are subject to audit and backup to ensure continuity of care and protection of patient information.

8.5 Photography and Clinical Images. When medically necessary, the Practice may obtain photographs or other clinical images for documentation of medical findings, procedures, wounds, skin lesions, or other clinical conditions. Such images become part of the patient's medical record and will be protected in the same manner as other Protected Health Information. Clinical photographs will not be used for education, publication, marketing, or other purposes without separate authorization unless otherwise permitted by law.

SECTION 9: OUR MODEL OF CARE

9.1 Mobile Direct Patient Care to the patient's facility consists of medical evaluation, diagnosis, treatment, medication management, psychotherapy when appropriate, neuropsychiatric evaluation, cognitive assessment, family education, behavioral management, and ongoing medical management provided directly to the patient.

- ☐ I understand that Cerebral Care Consulting, LLC is a mobile practice and that visits are scheduled based on medical necessity, clinical priority, facility operations, and physician availability rather than fixed appointment times.
- ☐ I understand that patients and family members are not expected to be present during routine visits. If I wish to meet with the treating physician, I should notify the Practice or facility in advance. The Practice will make reasonable efforts to coordinate my participation but cannot guarantee a specific appointment time or physician availability.
- ☐ I understand that routine updates and non-urgent communications may be provided by the Practice's clinical staff, facility staff, secure text messaging, the patient portal, or other appropriate communication methods, and that the treating physician may not contact family members after every patient encounter.
- ☐ I understand that the Practice welcomes communication and encourages patients and families to contact the Practice with questions or concerns. When feasible, the Practice will provide an estimated time range during which the physician is expected to be at the facility; however, exact arrival times cannot be guaranteed. Significant changes in condition or important treatment decisions will be communicated by the treating physician or other appropriate staff member.
- ☐ I understand that delays caused by repeated requests for discussion without new clinical information, conflicting instructions, inability to identify an authorized decision-maker, or delays in treatment decisions may interfere with timely medical care. I acknowledge that the Practice cannot guarantee outcomes when medically appropriate recommendations are delayed, declined, interrupted, or modified by the patient, legally authorized representative, family members, facility staff, or another healthcare provider.
- ☐ I understand that medical diagnosis and treatment recommendations are made using the independent professional judgment of the treating physician or other licensed healthcare professional, and that providers are not obligated to recommend or provide treatment that is unsafe, medically unnecessary, or inconsistent with accepted standards of care.

9.2 Electronic & Telephone, Provider-to-Provider Consult Care: These consultative services are requested by a patient's treating primary care physician or advanced practice provider to obtain specialty recommendations regarding diagnosis, cognitive disorders, behavioral symptoms, medication management, neuropsychiatric conditions, or other clinical questions. Depending upon the clinical circumstances, applicable law, and payer requirements, the consulting physician may review medical records, laboratory data, imaging studies, medication histories, and other available clinical information without conducting a face-to-face evaluation of the patient. Consultative recommendations are intended to assist the requesting clinician in medical decision-making. Unless the Practice subsequently establishes a direct physician-patient relationship with the patient, responsibility for implementing treatment recommendations and directing the patient's ongoing medical care remains with the requesting primary care physician or advanced practice provider.

SECTION 10: SCOPE OF CARE

10.1 The Practice provides physician-led evaluation, diagnosis, medication management, psychotherapy when clinically appropriate, neuropsychiatric evaluation, cognitive assessment, behavioral management, family and caregiver education, care coordination, and consultation for patients with neurological, psychiatric, and neurocognitive disorders.

10.2 The Practice does not provide emergency medical services, crisis stabilization, inpatient psychiatric treatment, or twenty-four-hour on-call coverage. Patients experiencing a medical or psychiatric emergency should call 911 or proceed to the nearest emergency department.

10.3 Professional services requested primarily for legal, administrative, employment, disability, insurance, educational, licensing, or forensic purposes are outside the Practice's scope of care. Examples include forms, letters, reports, certifications, appeals, record summaries unrelated to treatment, independent medical examinations, forensic evaluations, expert witness services, legal capacity opinions, and other services not medically necessary for diagnosis or treatment. Submission of a request does not obligate the Practice to review, complete, certify, sign, or respond. The Practice will provide an Advance Beneficiary Notice of Noncoverage (ABN) or other required notice when applicable. Insurance coverage does not determine medical necessity. The Practice's primary responsibility is the timely delivery of patient care.

SECTION 11: FINANCIAL RESPONSIBILITIES AGREEMENT

11.1 Insurance Verification and Coverage. I understand that the practice may verify my insurance benefits. However, verification of coverage is not a guarantee of payment by Medicare or any secondary insurance.
I understand that Medicare may not cover all psychiatric services.

11.2 Patient Financial Obligation. I am responsible for: Medicare deductible and coinsurance; Charges not covered by Medicare or secondary insurance; and any service I request that is not considered medically necessary by Medicare, including but not limited to: Completion of third-party forms, letters, and documentation (including long-term care insurance, disability paperwork, and capacity evaluations), which are not reimbursed by Medicare.

11.3 ABN Requirement and Purpose. Medicare requires that you receive an Advance Beneficiary Notice of Noncoverage (ABN) before you receive certain services that Medicare may not cover. The ABN informs you of your potential financial liability and allows you to decide whether to receive the service. You will be provided with a completed ABN form when the practice has reason to believe that Medicare will not cover a specific service, test, procedure, or item.

11.4 Principal Care Management (PCM) Services. I understand that this practice utilizes Principal Care Management (PCM) codes for the management of chronic conditions. PCM services may include remote monitoring, care coordination, and clinical management outside of face-to-face visits. These services are billed to Medicare and/or my insurance plan. I am financially responsible for any coinsurance, deductibles, or charges not covered by Medicare or my insurance, and I will be billed directly for such amounts.

11.5 Collaborative Care Model (CoCM) Services. I understand that this practice utilizes the Collaborative Care Model (CoCM) for provider-to-provider consultations related to behavioral health integration. CoCM services involve coordination with psychiatric consultants and care managers to support my treatment plan. These services are billed through Medicare and/or my insurance plan. I am financially responsible for any fees not paid by Medicare or my insurance, and I and/or my power of attorney (POA) will be billed for such amounts.

11.6 Assignment of Medicare Benefits. In accordance with Section 1842(b)(3)(B) of the Social Security Act, I hereby assign payment of authorized Medicare benefits to the Practice for any services provided by physicians or allied health providers in their employment or under their supervision.

11.7 Authorizations. I authorize: (1) Release of medical or other necessary information to the Centers for Medicare & Medicaid Services (CMS) and its agents to determine these benefits or related services; (2) The practice to appeal denials on my behalf when appropriate.
11.8 Medicare Advantage, Secondary & Supplemental Insurance. If applicable, I authorize the Practice to bill my Medicare Advantage Plan or secondary insurance, and to release any necessary medical information to process claims or coordinate care.
11.9 Notice Obligations. I agree to notify the practice immediately if: (1) My Medicare or secondary insurance coverage changes; (2) I acquire new coverage or my policy is terminated.
11.10 Acknowledgment of Financial Responsibility. As a patient of the Practice, I understand and agree to the following terms regarding my financial obligations for services received. I understand that: I am financially responsible for all non-covered services; This assignment will remain in effect unless revoked in writing.

SECTION 12: GOVERNING LAW AND VENUE. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee, without regard to its conflict of laws principles. To the fullest extent permitted by applicable law, any action or proceeding arising out of or relating to this Agreement, the treatment or services provided, or the physician-patient relationship shall be brought exclusively in the state or federal courts located in or serving Williamson County, Tennessee. Each party irrevocably consents to the personal jurisdiction and venue of such courts and waives any objection based upon improper venue or forum non conveniens.

SECTION 14: HIPAA ACKNOWLEDGEMENT AND CONSENT. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, pain, healthcare operations, and other described and permitted uses and disclosures. I understand that I need to contact the privacy officer if I have a question or complaint. Understanding this information may be disclosed electronically by the physician and/or the physician's Business Associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practice. I understand that I can revoke or modify this specific authorization, and that revocation or modification must be in writing. I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below.

Name:	Relationship:	Contact number:
_____	_____	_____
Name:	Relationship:	Contact number:
_____	_____	_____
Name:	Relationship:	Contact number:
_____	_____	_____

SECTION 13: URGENT CLINICAL DECISION-MAKING ACKNOWLEDGEMENT
I understand that the Practice provides specialty medical care for patients with neuropsychiatric and neurodegenerative disorders, many of whom experience conditions that may rapidly worsen if medically appropriate treatment is unnecessarily delayed. I understand that the Practice will make reasonable efforts to contact the patient or the patient's legally authorized representative before implementing treatment recommendations whenever consent is required and it is reasonably practicable to do so. If, after reasonable efforts, the patient or legally authorized representative cannot be reached in a timely manner and delaying care could reasonably increase the risk of serious harm, I authorize the treating Provider to exercise independent professional medical judgment and to recommend, coordinate, and communicate medically appropriate care to the patient's primary care provider, facility staff, hospice provider, pharmacy, or other treating healthcare professionals, to the extent permitted by applicable law and consistent with the applicable standard of care. Nothing in this acknowledgment authorizes treatment over the objection of a competent patient, limits the rights of a legally authorized representative under applicable law, or authorizes treatment prohibited by law. This acknowledgment is intended to confirm my understanding that timely medical decision-making is an essential component of safe medical care and that unnecessary delays may increase the risk of preventable complications. **Patient/Legally Authorized Representative Initials:** _____

SECTION 15: PATIENT ACKNOWLEDGMENT AND AGREEMENT

By signing below, I acknowledge and agree that:

- ☐ I voluntarily consent to receive medically appropriate evaluation, diagnosis, consultation, treatment, medication management, psychotherapy when indicated, care coordination, and other services provided by Cerebral Care Consulting, LLC and its physicians or other licensed healthcare professionals, subject to this Agreement and applicable law.
- ☐ If I am signing as the patient's legally authorized representative, I certify that I have the legal authority to make healthcare decisions for the patient and understand that the Practice may require documentation verifying that authority before relying upon it for non-emergent medical decisions.
- ☐ I acknowledge that I have read, understand, and agree to be bound by the terms and conditions contained in this Consent for Treatment Agreement.

Patient Full Legal Name: _____

Facility Name & Room Number: _____

Date of Birth: _____

Social Security Number: _____

Insurance Information:

Subscriber Name (if different): _____

Medicare ID / Policy #: _____

Medicare Group ID #: _____

Secondary Insurance ID #: _____

Secondary Group ID # _____

Supplemental Insurance ID #: _____

Supplemental Group ID # (*opt*): _____

Signature of Patient or Authorized Representative: _____

Printed Name of Authorized Representative: _____

Date: _____

CEREBRAL CARE CONSULTING

CONSENT TO RELEASE INFORMATION

Patient Name: _____ **Date of Birth:** _____

I, AUTHORIZE:

Organization/Physician	Location	Phone & Fax	**PURPOSE** Care Coordination
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

to DISCLOSE and RECEIVE information contained in my record TO and FROM,

CEREBRAL CARE CONSULTING
1906 Glen Echo Road. Nashville, TN 37215.
admin@cerebralcareconsulting.com
mobile: 615-619-6300 **fax: 615-619-6306**

The following information:

- All medical records, including medical, psychiatric, and drug treatment.
- The purpose of this disclosure is for medical, psychiatric, and drug treatment.

Expiration: This authorization expires 2 years after the date below or whenever Cerebral Care Consulting, LLC is no longer providing me with services.

Notice Prohibiting Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Signature of Patient or Authorized Representative: _____

Printed Name of Authorized Representative: _____

Date: _____