CEREBRAL CARE CONSULTING

CONSENT FOR TREATMENT

TO THE PATIENT: You have the right, as the patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment by this practice or any other practice under common ownership. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue medical care(services).

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test offered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request that a physician and other healthcare providers, or their designees, perform a reasonable and necessary medical examination, testing, and treatment for the condition, for which I seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure (s).

NOTICE OF PRIVACY POLICY: This notice describes how health information about you may be used and disclosed, and how you can access this information. Each time you visit our practice, or 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. 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. The following categories describe examples of the way we use and disclose health information:

- For treatment: We may use health information about you to provide you with treatment or services.
- 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. For example, we may need to provide your insurance company with information about your surgery so they can pay us or reimburse you for the treatment. We may also tell your health plan about the treatment you are going to receive to determine whether your plan will cover it.
- To remind you that you have an appointment for medical care.
- To assess your satisfaction with our services.
- To tell you about possible treatment alternatives.
- To tell you about health–related benefits or services.
- For population-based activities relating to improving health or reducing health care costs;
- For conducting training programs or reviewing the competence of health care professionals, and
- To a Medicaid eligibility database, as applicable.
- When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Some services are provided through contracted business associates. Examples include Spruce Health, RXNT, eCW, Google Workspace, 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.

We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort to assist with the provision of this notice.

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 our practice is participating in.

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.

If applicable, protected health information will be made available to your senior living personnel as necessary to carry out treatment, payment, and health care operations.

Federal and state laws may permit us to participate in organizations 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. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to: Food and Drug Administration, Public health or legal authorities charged with preventing or controlling disease, injury or disability, Correctional institutions, Workers' compensation agents, Organ and tissue donation organizations, Military command authorities, Health oversight agencies, Funeral directors and coroners, National security and intelligence agencies, Protective services for the president and others, A person or persons able to prevent or lessen a serious threat to health or safety. We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime. We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected health information for marketing purposes, or to sell your protected health information.

Many states have requirements for reporting, including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may impose additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

YOUR HEALTH INFORMATION RIGHTS: Although your health record is the physical property of our practice, you have the right to: 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.

An accounting of disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

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.

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.

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.

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.

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.

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.

PATIENT RIGHTS AND RESPONSIBILITIES: 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.

- 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.
- 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.
- 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.
- Informed Consent: Make informed decisions about care, including being advised of the risks, benefits, and alternatives before consenting to treatments or procedures.
- Access to Care: Receive timely medical care and be informed of provider credentials upon request.

- Billing and Insurance: Be informed in advance about charges and services not covered by insurance. Receive an itemized bill and explanations upon request.
- 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
- 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.

Patient Responsibilities: Give true and complete information about your health status, medical history, hospitalizations, medications, contact info, and caregivers. Notify us of risks, changes in your condition, safety concerns, or violations of your rights. Let us know if you understand your care plan or if you need further clarification. Follow your care plan and instructions provided by your health care team. Keep your appointments or notify us at least 24 hours in advance if you must cancel. Accept responsibility for consequences if you refuse care or do not follow medical advice. Pay your healthcare bills in a timely manner. Comply with our practice procedures, policies, and regulations. Respect the rights of other patients and staff, and maintain appropriate behavior. Help us assess and manage your pain, and communicate concerns about pain treatments. Understand that disrespectful or abusive behavior may result in dismissal from the practice. Accept that we may end our relationship with you if you do not follow your care plan or doctor's orders.

CONSENT FOR TELEHEALTH AND TECHNOLOGY: Telehealth includes the delivery of healthcare services via electronic communications such as interactive audio, video, and/or data communications. The services may include: Evaluation, diagnosis, consultation, and treatment**.** Transmission of medical records, images, and lab reports**.** Remote monitoring and follow-up**.** Patient education and self-management guidance**.** Providers using telehealth technology are licensed in the State of Tennessee and are authorized to deliver care through virtual platforms as permitted under Tennessee Code Annotated § 63-1-155 and applicable federal law. By signing this consent, I understand and agree to the following: I will receive services using technology, including video conferencing, telephone, secure text messaging, or email. The provider has explained the risks and benefits of telehealth services. I may decline or withdraw my consent to telehealth services at any time without affecting my access to future care or treatment. I have the right to request in-person care when available and clinically appropriate. I understand that telehealth has limitations, including potential technology failure, privacy limitations, or the provider's inability to conduct certain examinations. I am responsible for ensuring privacy on my end of the communication (e.g., using a private room, secure connection, etc.). If the telehealth platform fails, the provider may contact me via alternative methods such as telephone. By signing this document, I authorize Cerebral Care Consulting, LLC 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.

All information shared during a telehealth encounter is protected by the same privacy laws (HIPAA) that apply to in-person care. Reasonable and appropriate measures will be taken to protect the confidentiality of all communications and patient information. I understand that Cerebral Care Consulting, LLC 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, decision-support systems, or electronic prescribing.

I understand that telehealth is not appropriate for emergency situations. In the event of an emergency, I will call 911 or proceed to the nearest emergency room.

This consent remains in effect unless revoked in writing. I may withdraw consent at any time by notifying the practice in writing.

FINANCIAL RESPONSIBILITIES AGREEMENT: As a patient of Cerebral Care Consulting, LLC, a medical practice, I understand and agree to the following terms regarding my financial obligations for services received:

- Insurance Verification: I understand that, as a courtesy, the practice may verify my insurance benefits. However, verification of coverage is not a guarantee of payment by Medicare or any secondary insurance.
- Medicare Coverage: I understand that Medicare may not cover all psychiatric services (including some therapy modalities, assessments, or non-face-to-face services). I will be notified in writing (via an Advance Beneficiary Notice, or ABN) if services are deemed non-covered.

- 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) is billed per page and per letter, as these services are not reimbursed by Medicare. Applicable fees will be discussed prior to completion.
- Payment Terms: I agree to pay any balance not covered by insurance upon receipt of a statement. Payment may be made via cash, credit card, or any other method accepted by the practice.
- 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 Cerebral Care Consulting, LLC for any services provided by physicians or allied health providers in their employment or under their supervision.
- 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
- The practice to appeal denials on my behalf when appropriate

If applicable, I authorize Cerebral Care Consulting, LLC to bill my Medicare Advantage Plan or secondary insurance, and to release any necessary medical information to process claims or coordinate care. I agree to notify the practice immediately if:

- My Medicare or secondary insurance coverage changes
- I acquire new coverage or my policy is terminated.

I understand that:

- I am financially responsible for all non-covered services
- This assignment will remain in effect unless revoked in writing
- A photocopy or electronic version of this form is as valid as the original

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 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:
Name:	Relationship:	Contact number:

Patient/Authorized representative may revoke or modify this specific authorization, and that revocation or modification must be in writing. I agree that the physician or an agent of the physician may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

I consent to photographs, visual audio recordings, and/or images being recorded for patient care, security purposes, and or the practice's healthcare operations purposes. I understand that the practice retains ownership rights of the images and/your recordings. I will be allowed to request access to or copies of the images and or recordings when technologically feasible less otherwise prohibited by law. I understand that these images and recordings will be securely stored and protected. Images and the recordings that I am identified in will not be released and/or used

outside the practice without a specific written authorization for me or my legal representative, unless otherwise permitted by law.

Consent to email, cell or television, or text usage for appointment reminders and other healthcare communications: If at any time I provide an email address or cell phone number at which I may be contacted, I consent to receiving and secure instructions and other healthcare communications at the email or text address I provided you or your EPO service or have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: Postprocedural instructions, follow-up instructions, educational information, and prescription information. Other healthcare communication may include, but is not limited to, communications to family or designated representatives regarding my treatment or conditions, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications anytime. The practice/clinic does not charge for this service; bystander text messaging rates or cellular telephone minutes may apply, as provided in your wireless plan (contact your carrier for pricing plans in detail.

Release of information: I hereby permit the practice and the physicians or other healthcare professionals involved in the patient care to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information regarding a prior visit with the practice may be made available to any person or entity liable for payment on the patient's behalf, to verify coverage, or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employers at any time when the services delivered are related to a claim under Workers' Compensation.

If Medicare or Medicaid covers me, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of the Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurses' notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment, and discharge summary.

State laws may permit this practice to participate in organizations with other healthcare providers, ensures, and/or other healthcare industry participants in their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: Improving accuracy, increasing the availability of my health record decrease in the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this practice may be a member of one or more such organizations. This consent includes explicit information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases, including but not limited to, blood-borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Printed Name of Patient: _____

Signature of Patient or Authorized Representative:

_____

Date: _____

Printed Name of Patient or Authorized Representative: _____

Relationship to Patient (if applicable): _____

CONSENT TO RELEASE INFORMATION

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

I, AUTHORIZE:

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

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.

Printed Name of Patient: _____

Signature of Patient or Authorized Representative:

_____

Date: _____

Printed Name of Patient or Authorized Representative: _____

Relationship to Patient (if applicable): _____