Houston
SLEEP AND NARCOLEPSY

www.sleepandnarcolepsy.com
Tel: 713-465-9282
Fax: 877-358-9344

Patient Consent

NAME OF PATIENT	DOB (MTH/DAY/YEAR)	DATE

NAME OF PATIENT'S REPRSENTATIVE	RELATION TO PATIENT

Notice of Privacy Practices Acknowledgement

I hereby consent to the use or disclosure of individually identifiable or protected health information (PHI) by Houston Sleep and Narcolepsy in order to carry out treatment, payment, or health care operations. I acknowledge that Houston Sleep and Narcolepsy has provided a copy of the Notice of Privacy Practices as required by law.

Houston Sleep and Narcolepsy reserves the right to change the terms of its Notice of Privacy Practices for PHI at any time and must notify the patient. The patient retains the right that Houston Sleep and Narcolepsy further restrict how the PHI is used or disclosed. Houston Sleep and Narcolepsy is not required to agree to such requested restrictions; however, if Houston Sleep and Narcolepsy does agree to patient requested restriction(s), such restrictions are then binding on Houston Sleep and Narcolepsy.

The patient retains the right to revoke this consent. Such revocation must be submitted to Houston Sleep and Narcolepsy in writing. The revocation shall be effective immediately to the extent that Houston Sleep and Narcolepsy has already taken action in reliance to the consent.

Houston Sleep and Narcolepsy may refuse to treat the patient if he/she (or an authorized representative) does not sign this consent form (except to the extent that Houston Sleep and Narcolepsy is required by law to treat individuals). If the patient (or authorized representative) signs this consent form and then revokes consent, Houston Sleep and Narcolepsy has the right to refuse to provide further treatment to the patient at of the time of revocation (except to the extent that Houston Sleep and Narcolepsy is required by law to treat individuals).

General Consent to Treat

I authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Houston Sleep and Narcolepsy and their designated associates believe are necessary. I understand that by signing this form, I am giving permission to the practitioners in this office to provide treatment as long as a practitioner/patient relationship exists, or until I withdraw my consent in writing.

Treatment of Minor, if applicable: I, as the parent/legal guardian of a minor receiving treatment, do hereby agree and understand that I have been advised to remain on the premise during any such treatment, and waive any claim I may have resulting from failure to do so.

Office Policy and Financial Policy

I acknowledge that I have been provided a copy of Houston Sleep and Narcolepsy Office and Financial Policy and I understand the terms.

Electronic Prescribing

I voluntarily authorize Houston Sleep and Narcolepsy to allow E-prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice and review medication history as long as a practitioner/patient relationship exists, or until I withdraw my consent in writing.

Voicemail, Texts, and E-mail Notifications

Houston Sleep and Narcolepsy provides courtesy appointment reminder calls/texts/emails and possibly other important calls or reminders that may be placed by a staff member or by using a prerecorded auto messaging system. This information may include PHI. I understand that by signing this form, I give consent to receive such calls/texts/emails at the number/email addresses I have provided unless specific restrictions have been provided in writing.

Assignment of Benefits

I, the undersigned, authorize payment of medical benefits to Houston Sleep and Narcolepsy for any services furnished to the patient by the practice. I also authorize you to release to my insurance company or their agent, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims benefits.

I have read this form, had the opportunity to ask questions and accept the terms and conditions as stated.

PRINTED NAME OF PATIENT/PARENT/LEGAL GUARDIAN	SIGNATURE	DATE (MTH/DAY/YEAR)