NORAN NEUROLOGICAL CLINIC P.A. AND MINNESOTA DIAGNOSTIC CENTER
AUTHORIZATION AND CONSENT FORM

General Release of Information & Assignment of Benefits:
I authorize Noran Neurological Clinic, on behalf of myself and/or my dependents, to furnish medical records, including films and other information related to health care services provided by Noran Neurological Clinic or the Minnesota Diagnostic Center, to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which Noran Neurological Clinic or the Minnesota Diagnostic Center participate, and the contractors and third party administrators of any of these parties, as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled, and I request payment of all such authorized benefits be made on my behalf, to Noran Neurological Clinic for any services furnished by Noran Neurological Clinic or the Minnesota Diagnostic Center.

Release of Information by Payers and Networks:
I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators, to share my health records and information obtained from Noran Neurological Clinic or the Minnesota Diagnostic Center, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which Noran Neurological Clinic or the Minnesota Diagnostic Center participates, and the contractors and third party administrators of these parties, as needed for payment and health care operations.

Payment Agreement:
I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage.

Release/Retrieval of Information to/from Health Care Facilities, Pharmacy Benefit Payers and Providers: I authorize the release or retrieval of my medical treatment information, including films, prescription medication history and other information related to such services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.

Voicemail & Text Messages:
I authorize Noran Neurological Clinic to use and disclose medical information to contact me in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to me. Noran Neurological Clinic may call me and, if necessary, leave messages on my answering machine. Noran Neurological Clinic may send text message appointment reminders to my mobile device.

Patient Information:
_____By initialing, I acknowledge that I have received the Notice of Privacy Practices of the Noran Neurological Clinic/Minnesota Diagnostic Center.

I understand all of the above and I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at anytime and that my revocation shall have no effect on any actions taken prior to my revocation.

_____ _____
Patient's Name (print) **Date

_____ _____
Signature of Patient (or Personal Representative) Relationship to Patient if Patient Unable to Sign

NAME_____ DOB: _____

Insurance Coverage Information

Motor Vehicle Insurance Information

Minnesota is a no-fault state. All claims go through the patient's auto insurance regardless of fault.

Motor vehicle insurance carrier: _____

Date of injury: _____ Claim number: _____

Claims address: _____

Policy number: (only needed if claim number is not available): _____

Name and phone of the adjuster assigned: _____

Are you being treated for a motor vehicle related condition?.....Yes___ No ___

If yes, has your case been settled?.....Yes___ No ___

Is your case being denied?.....Yes___ No ___

Do you have an attorney?.....Yes___ No ___

Attorney's Name: _____ **Attorney's Phone Number:** _____

☐ Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Worker Compensation Insurance Information

Name of Employer at time of injury: _____

Workers Comp insurance carrier: _____

Date of injury: _____ Nature of injury: _____

Claim number: _____

Claims address: _____

Name and phone of adjuster assigned to claim or contact at employer: _____

Are you being treated for a work related injury or condition?.....Yes___ No ___

If yes, has your case been settled?.....Yes___ No ___

Is your case being denied?.....Yes___ No ___

Was a Motor Vehicle involved in the injury?.....Yes ___ No ___

Do you have an attorney?.....Yes___ No ___

Attorney's Name: _____ **Attorney's Phone Number:** _____

☐ Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Other Injury Information

Insurance carrier covering injury: _____

Date of injury: _____ Nature of injury: _____

Claim number: _____

Claims address: _____

Do you have an attorney?.....Yes___ No ___

Attorney's name: _____ **Attorney's phone number:** _____

☐ Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Health Insurance

Primary Insurance information-

Name of insurance: _____ Insurance ph# _____ Effective date: _____

Policy number: _____ Group or account number: _____

Subscriber's name: _____ Subscribers date of birth: _____

Secondary Insurance information-

Name of insurance: _____ Insurance ph# _____ Effective date: _____

Policy number: _____ Group or account number: _____

Subscriber's name: _____ Subscribers date of birth: _____