stratus

PATIENT SERVICE AUTHORIZATION AND PLAN OF SERVICE FOR ELECTROENCEPHALOGRAM (EEG) AND/OR ELECTROCARDIOGRAM (EKG)

Patient Name:_____ **DOB:**_____ **Date:**_____

Patient Initials

PATIENT SERVICE AUTHORIZATION

_____ **Authorization/Consent for Care/Service:** I authorize Alliance Family of Companies, LLC and/or its subsidiaries and/or affiliates, d/b/a Stratus ("Company") to provide electroencephalographic and/or electrocardiogram diagnostic services as prescribed by my physician. I understand that my physician is referring me to Company for this diagnostic testing and consent to this referral. I understand that I have the right to select a service provider other than Company for this testing.

_____ I have ***NO*** known or suspected history of skin sensitivities or allergies to cosmetics, lotions, adhesives or latex products.

_____ I ***DO*** have a history of skin sensitivities or allergies to cosmetics, lotions, adhesives or latex products.

_____ **Patient Responsibilities/Consent:** I understand that I am responsible to ensure that all pre-authorization and enrollment requirements are fulfilled and that any policy changes are reported to Company immediately. I understand that in the event that there is a lack of coordination of benefits, if the payment is made directly to the patient or if services are deemed not medically necessary, payment may be denied by my insurer and I may be fully responsible for payment. I also understand that I am responsible for confirming benefit and coverage information provided by my insurer to Company. I also understand and agree that the technical component of my testing will be sent to a neurologist to perform the professional component, and such neurologist will bill for professional interpretation services that he/she renders.

_____ **Release of Information:** I hereby request and authorize the Company, prescribing physician, hospital, and any other holder of information relevant to services provided by Company to release information upon request to any payer source, physician, or any other medical personnel or agency involved with services provide by Company. I also authorize Company to review medical history and payer information for the purpose of providing me with services.

_____ **Communication via E-mail/Phone:** I consent to communication from the Company to me, via personal e-mail, and/or phone calls, and/or text messaging. I understand that I may opt out of any of these options at any time.

_____ **Consent to Record Video & Audio:** I consent to video and audio recordings for use of the services provided by Company. I consent to have such recordings made available by Company to medical professionals as may be required to complete the professional component of the diagnostic testing.

_____ **Patient Handouts:** I acknowledge that I have received a copy of the Patient Handouts which contains the Patient Rights and Responsibilities, Grievance/Complaint Reporting and the Notice of Privacy Practices. I acknowledge that the information provided in the handouts has been explained to me and that I understand the information.

_____ **Advance Directives:** ☐ I ***DO*** have or ☐ I ***DO NOT*** have Advance Directives, check one.

_____ **Grievance/Complaint Reporting:** I acknowledge that I have been informed of the procedures to file a grievance/complaint should I become dissatisfied with any portion of my services. I understand that I may file a grievance/complaint without concern for reprisal or discrimination at any time.

Patient Signature: _____ **Date:** _____

Signature of Parent, if Patient is a minor _____ **Date:** _____

If the patient is a minor, the signature of a parent, guardian, or other legal representative is required.

Printed Name: _____ **Relationship:** _____

Signature of Patient's legal representative, * if applicable: _____ **Date:** _____

If an adult patient is not competent to make his/her own medical decisions, a Medical Power of Attorney, or its equivalent, is required.

Printed Name: _____ **Relationship:** _____

Tech Initials

PLAN OF SERVICE

_____ Perform the patient assessment, review the service(s) prescribed by the physician and provide patient education of Electroencephalogram and/or Electrocardiogram and instructions for obtaining follow-up services and study results. Provide an opportunity to answer any additional questions the patient or the patient's representative may have regarding this authorization or the services. Proceed to conduct the ordered services.

Technologist Signature: _____ **Date:** _____

Printed Name: _____

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PATIENT'S ASSIGNMENT OF BENEFITS AND PAYMENT, AUTHORIZATION OF PAYMENT, AND/OR DESIGNATION OF AUTHORIZED REPRESENTATIVE

Patient Name: _____ **DOB:** _____ **Date:** _____

Patient Address: _____

In connection with and in exchange for any and all electroencephalographic and/or electrocardiogram diagnostic services provided to me by or through Alliance Family of Companies, LLC and/or its subsidiaries and/or affiliates, d/b/a Stratus ("Company") and in exchange for the Company directly filing claims for services on my behalf:

_____ *(Initials)* **Assignment of Benefits and Payments:** I hereby irrevocably assign to Company all my rights to any of my insurance plans, health benefit plans, or any other source of payment for health or medical coverage of any kind, including but not limited to, commercial, private, government, administrated, and ERISA plans (collectively "Health Plans"), as allowed by contract and by law, related in any manner to the determination of benefits and payment for the services performed and/or provided to me by Company.

This assignment specifically includes, but is not limited to, Company's right to directly file a claim for services with my Health Plans, to be directly paid for said services by my Health Plans, to communicate with and provide medical records and documents to my Health Plan to obtain payment consideration and reconsideration, to seek redeterminations of denied claims from my Health Plans, to appeal denials of claims by my Health Plans, to request and receive my Health Plan documents, to seek and be entitled to interest and penalties for underpayments and late payments by my Health Plan, and to file complaints and/or legal actions (mediations, arbitrations, and lawsuits, as applicable) against my Health Plan regarding disputed benefits, denials, and/or payment-related issues at Company's discretion.

If my Health Plan, law, or interpretation of law prevents any portion of and/or all of the assignment of benefits and payments set forth above:

_____ *(Initials)* **Authorization of Payment:** I hereby irrevocably authorize Company to file a claim for services on my behalf with my Health Plans and further irrevocably authorize and request that my Health Plan directly pay Company for said services provided under my Health Plans.

_____ *(Initials)* **Designation of Authorized Representative:** I also voluntarily designate the Company as my duly authorized representative, to whom I grant absolute power and legal authority, to communicate with and provide medical records with protected health care information and documents to my Health Plan to obtain payment consideration and reconsideration for performed services, to seek redeterminations of denied claims for Company's services from my Health Plans, to appeal denials of claims by my Health Plans of Company's services, to request and receive my Health Plan documents, to seek and be entitled to interest and penalties for underpayments and late payments by my Health Plan and to file complaints and/or legal actions (mediations, arbitrations, and lawsuits, as applicable) against my Health Plan regarding disputed benefits, denials, and/or payment-related issues at Company's discretion.

The forgoing designation of authorized representative will remain in effect for a period of eighteen (18) months.

However, I understand I may voluntarily revoke my designation of authorized representative at any time by notifying both Company and my Health Plans, in writing, of my revocation of this designation.

I further understand that a written revocation will not have any effect on actions taken by Company or my Health Plans prior to receipt and process of the written revocation.

Patient Signature: _____ **Date:** _____

Signature of Parent, if Patient is a minor: _____ **Date:** _____
If the patient is a minor, the signature of a parent, guardian, or other legal representative is required.

Printed Name: _____ **Relationship:** _____

Signature of Patient's legal representative, * if applicable: _____ **Date:** _____
If an adult patient is not competent to make his/her own medical decisions, a Medical Power of Attorney, or its equivalent, is required.

Printed Name: _____ **Relationship:** _____
(*If legal representative, please attach a copy of legal authorization; e.g. a power of attorney, guardianship, etc.)

STRATUS

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

Patients have specific rights as well as responsibilities which Alliance Family of Companies, LLC and/or its subsidiaries and/or affiliates, d/b/a Stratus ("Company") respects and adheres to. We have provided some information for you below to inform you of your rights and responsibilities, you have the right to:

- Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care
- Be informed in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible
- Receive information about the scope of services that the organization will provide and specific limitations on those services
- Refuse care or treatment after the consequences of refusing care or treatment are fully presented
- Have one's property and person treated with respect, consideration and recognition of client/patient dignity and individuality
- Be able to identify personnel members through proper identification
- Be free from mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source and misappropriation of client/patient property
- Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal
- Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated
- Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information
- Be advised on the organizations policies and procedures regarding the disclosure of clinical records
- Choose a health care provider
- Receive appropriate care without discrimination in accordance with physician orders
- Be informed of any financial benefits when referred to an organization
- Be fully informed of one's rights and responsibilities

GRIEVANCE/COMPLAINT REPORTING

You may file a complaint without concern of reprisal or discrimination at any time you are not satisfied or concerned with the level of service provided by our organization.

To file a grievance or complaint for EEG/EKG services, please call **469-995-8416, ext. 1** and request to speak with a *EEG/EKG Patient Services Coordinator* who will be able to assist you. If you feel your complaint is not resolved to your satisfaction within 5 business days, you may initiate a formal grievance, in writing and forward it to the Compliance Department at the address listed below. You will receive a written response within 14 business days upon receipt.

Corporate Office: Stratus
4545 Fuller Drive, Suite 100
Irving, Texas 75038
469-995-8416

NOTICE OF PRIVACY PRACTICES - STRATUS

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

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan and billing-related information. This information is considered protected health information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you and comply with the Health Insurance Portability and Accountability Act (HIPAA). It also describes your rights and certain obligations with regard to your medical information and applies to all of the records of your care generated by your healthcare provider(s) for our organization.

Our Responsibilities

Alliance Family of Companies, LLC and/or its subsidiaries and/or affiliates, d/b/a Stratus ("Company") is required to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information that we collect and maintain.

We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain. Copies of our Notice are available in our patient packets, our facilities and on our website.

How We May Use and Disclose Medical Information about You

The following describes examples of the way we may use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other healthcare professionals such as physicians, nurses, technicians, clinical laboratories, imaging centers, medical students, or other personnel who are involved in your care.

We may communicate your information using various methods, orally, written, facsimile and electronic communications.

We may also provide other healthcare professionals who contribute to your care with copies of various reports and information to assist him/her and ensure that they have appropriate information regarding your condition/treatment plan and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. Examples may include contacting your insurance company for referrals, verification or pre-approval of covered services.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. We may contact you to remind you of your appointment via personal e-mail, and/or phone calls, and/or text messaging unless requested to opt out.

Business Associates, BA: Provide services for our organization through written contracts and/or service agreements. Examples of these services include billing and collection and software support. We may disclose your health information to a BA so they can perform the services we have asked them to do such as billing your third-party payer for services rendered. The BA is also required by law to protect and safeguard your health information which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

Breach Notification: In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA you will be notified within 60 days of the breach. In addition to your individual notification we may be required to meet further reporting requirements set forth by state and federal agencies.

Uses and Disclosures That May Be Made *With* Your Consent, Authorization or Opportunity to Object

We will not use and disclose information without your written authorization, except as described in this Notice or as required by applicable laws. Written authorization is required for, most uses and disclosures of psychotherapy notes; PHI for marketing purposes unless we speak with you and disclosures that may constitute a sale of PHI. If you provide an authorization to use or disclose medical 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 medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your authorization.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate with you via newsletters, mailings or other means regarding treatment options and information on health-related benefits or services; to remind you that you have an appointment; or other community based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving these communications, please contact our Privacy Officer.

Marketing and Fundraising initiatives, if applicable are limited and may require a separate authorization.

Uses and Disclosures That May Be Made *Without* Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to 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, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State-Specific Requirements: Many states have reporting requirements which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and others.

Your Health Information Rights

Although your health record is the physical property of the organization that compiled it, you have the right to:

Inspect and Copy: You and/or your personal representative have the right to inspect, review and receive a copy of your medical information. Electronic copies are available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We may deny your request to inspect and copy in limited circumstances to include release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Requests to copy and/or a review must be submitted in writing to Company. There will be a fee charged for all applicable copying and producing copy of portable media (CD, DVD, USB) up to the maximum amount as prescribed by governing law.

Amend: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing providing a reason to support the amendment request. You will be notified of the decision of your request in writing within 60 days.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment and health care operations. Company will provide the first accounting to you in any 12-month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12-month period will be up to the maximum amount prescribed by governing law.

Request Restrictions: You have the right to request a restriction or limitation of your medical information we use or disclose about you for treatment, payment or health care operations. *Restrictions from your health plan (insurance company)*: You have the right to request that we restrict disclosure of your medical information to your health plan for covered services; provided the disclosure is not required by other laws and services must be paid in full by you. *Other Restrictions, Limiting Information:* You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.

We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternate phone number or mailing address. We ask that you submit these requests in writing.
E-mail communication requests if applicable may require a separate authorization.

To exercise any of your rights, please submit your request in writing to the organization's privacy officer indicated below.

For More Information or to Report a Problem

If you have questions and would like additional information, please contact the Privacy Officer. If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy Officer at the contact number below or with the Secretary of Health and Human Services at 800-368-1019. Further instructions for filing a complaint can also be found at www.hhs.gov/ocr. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred and there will be no retaliation for filing a complaint.

Privacy Officer: Compliance Officer
Telephone Number: 469-995-8416

Corporate Office: Stratus
4545 Fuller Drive, Suite 100
Irving, Texas 75038

Effective Date: September 1, 2013 rev. 9.2020