

General Consent to Care and Release of Information
Ambulatory EEG Recordings

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Address _____ City _____

State _____ Zip Code _____ Home Phone Number (_____) _____

Social Security Number _____ Date of Birth _____ Sex M F

Email Address _____

Work Telephone Number (_____) _____ Patient's Employer _____

Family Physician _____ Referring Physician _____

Emergency Contact _____ Phone Number _____

MINOR INFORMATION (The following must be completed if patient is a minor)

Parent/Guardian _____ Phone Number _____

Address _____

City _____ State _____ Zip Code _____

HEALTH INSURANCE (Please attach a copy of front and back of insurance card(s)).

PRIMARY INSURANCE _____ Address _____

City _____ State _____ Zip Code _____ Tel. Number _____

Cardholder Name _____ Date of Birth _____

Relationship to Patient _____

ID Number _____ Group Number _____

SECONDARY INSURANCE _____ Address _____

City _____ State _____ Zip Code _____ Tel. Number _____

Cardholder Name _____ Date of Birth _____

Relationship to Patient _____

ID Number _____ Group Number _____

CONSENT TO CARE AND RELEASE OF INFORMATION TO INSURANCE COMPANIES

I hereby consent to medical care and treatment by Ambulatory EEG Recordings, LLC, including interpreting physicians. In rare cases a patient may have a reaction at the electrode site, which may include sensitivity, scabbing and/or even scarring. Knowing this, I agree to waive, release, and discharge Ambulatory EEG Recordings, LLC from any and all liability, claims, demands, actions, and causes of actions whatsoever, except to the extent prohibited by Wisconsin Statutes, for any loss, claim, damage, injury, illness, attorney's fees or harm of any kind or nature to me because of any sensitivity, scabbing and/or scarring at an electrode site. I authorize the release of any medical information or other information necessary to process my claim/charges. I also request payment of government benefits to Ambulatory EEG Recordings, LLC, and/or interpreting physicians for services rendered. I understand that I will be responsible for my bill not payable by my insurance, as well as all applicable co-payments, co-insurance and deductibles not paid at the time of service. I authorize Ambulatory EEG Recordings, LLC, and any interpreting physicians to act as my agent in helping me obtain payment from my insurance company and any required pre-certification. I acknowledge that I have received the written Notice of Privacy Practices from Ambulatory EEG Recordings, LLC. This authorization and waiver is in effect until I revoke it.

Signature _____ Date _____
Patient or Guardian