NeuLine HEALTH

PATIENT CONSENT FORM | ORDER FORM # _____

I, _____, agree to undergo video electroencephalography (EEG) testing by NeuLine Health Management LLC (NeuLine), which my healthcare provider has requested to further understand my medical condition.

I understand that video EEG testing involves the placement of recording electrodes over my scalp and the recording of brain activity and that video is used to record me during the video EEG test. I also understand I may be asked to breathe heavily and stare at a flashlight at the beginning of the video EEG test. NeuLine has informed me that there are no known side effects of this procedure, as its purpose is to measure and record, not to provide therapy or treatment. I have been properly informed of the risks, complications, consequences, and benefits, and I acknowledge that no guarantees regarding video EEG testing have been made. The alternative to video EEG testing is to not have it performed, in which case information regarding any central nervous system or neurological disorders will not be specifically obtained.

I understand that such video and audio recordings will be used for clinical purposes or in the event of legal action regarding your medical services. NeuLine is hereby released without recourse from any liability arising from obtaining and using such video recordings. No use of the video content (material) for any purpose outside my own clinical treatment plan will identify me by name.

I understand that my insurance company may require NeuLine to gain prior authorization and/or assignment of benefit (AOB) privileges when communicating with my insurance company on behalf of my claim.

I authorize NeuLine to obtain these privileges on my behalf. Should my insurance company provide me with the funds directly to pay for NeuLine's services, I understand that I am responsible for redirecting the full payment to NeuLine.

I understand that NeuLine may bill my insurance company in-network or out-of-network, depending on which billing scenario will benefit it best. NeuLine has covered its patient billing policy with me, in the event that any remaining deductibles or coinsurance amounts are applied by my insurance company.

My questions regarding video EEG testing services by NeuLine have been answered, and I acknowledge the above information and desire to proceed with video EEG testing.

PATIENT AUTHORIZATION

Signature of Patient/Authorized Representative: _____

Authorized Representative Relationship to Patient (if applicable): _____

Date: _____

1402 S. Custer Rd., Ste. 302, McKinney, Texas 75072-1452
PHONE: 844.212.5321 | FAX: 214.975.2270 | SUPPORT@NEULINEHEALTH.COM | NEULINEHEALTH.COM