COLORADO NEURODIAGNOSTICS, PLLC
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OFFICE POLICY

Dear Patient:

By establishing care with our office, you agree to abide by our office policies as listed below. Please keep a copy of our policies for your records.

CONSENT TO TREAT: I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that COLORADO NEURODIAGNOSTICS, PLLC will share patient health information according to federal and state law for treatment, payment and operations.

PRESCRIPTION REQUEST POLICY: We require at least 72-business hours' notice for ALL prescription requests. The quickest way to request a REFILL is to call your pharmacy and they will fax us a refill request. If you need a NEW prescription, call us with the name of the medication and dose you are taking and a pharmacy telephone number. New medications or medications changes may require a follow-up visit with your doctor.

PHONE MESSAGE POLICY: Due to the high volume of telephone calls, it may take 48 hours for our office to return your message. It is important to leave a detailed message with the office staff to avoid further delay of getting your message to the doctor. If you have not had an office visit within the last 30 days, you must make an appointment to discuss medications, new symptoms, or test results. These issues will not be discussed over the telephone.

LENGTH OF APPOINTMENTS: New patient appointments are scheduled 40-60 minutes and follow-up appointments are scheduled 20 to 30 minutes, depending on complexity. Please be respectful of the physician's time and considerate of patients whose appointments follow yours.

MEDICAL RECORDS POLICY: Due to the high volume of requests, we require 5-10 business days to fill medical records requests. You are entitled to one free copy of your medical records for yourself per year. For multiple copies, we charge $14.00 for the first 10 pages, pages 11-40 are 50 cents per page, then pages 41 and over are 33 per page per Colorado Department of Public Health and Environment standards. We require a signed medical records release form to send records to other medical facilities.

By signing below, you acknowledge that you have read and understand our office policy and agree to the terms. The medical office assistant will copy this for your records as well.

_____ _____

Signature of Patient or Guardian | Relationship of signer on behalf of patient

_____ _____

Printed Patient Name | CND Staff Initials