

VAUGHT NEUROLOGICAL SERVICES, PLLC

**Receipt of Notice of Privacy Practices
Written Acknowledgement**

I, _____, have received a copy of Vaught
(Patient's Name)

Neurological Service's, PLLC Notice of Privacy Practices.

Signature of Patient or Patient Representative

Date

After Hours/Appointment No-Show Policy Acknowledgement

I, _____ understand that the office hours for Vaught -
Neurological Services are as follows: Monday-Friday 8:00 am - 5:00 pm. If you have an emergency after
hours please call 911 or go to the Emergency Room. We do not take any calls after business hours.

I, _____ have read Vaught Neurological Services, PLLC
Appointment No-Show Policy, which is as follows: I understand that after the first no-show I will be charged
a "no-show" fee of \$35.00 that must be paid prior to rescheduling. In the event of two no-shows, I will be
unable to schedule another appointment at this office.

Signature of Patient or Patient Representative

Date

Authorization to Release Medical Information to Your Physicians

The undersigned authorizes Vaught Neurological Services to release information from the patient's medical
records to any referring physician, to any healthcare facility to which the patient may be transferred, and/or
to any healthcare provider involved in the patient's care.

Unless otherwise restricted by applicable law, this authorization to release medical records includes the
release of medical record information for all health care services that previously have been or will, in the
future, be provided by Vaught Neurological Services, and this authorization to release medical records is
not restricted to those health care services rendered in connection with this visit and may include
information gathered from other health care providers.

Patient or Designated Surrogate Signature

Date

Patient or Designated Surrogate Printed Name
