

**Sudbury Neurology, PLLC**  
 Authorization To Use, Disclose, or Obtain  
 Personal Health Information

Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

**I understand that, by signing this Authorization, I am authorizing Sudbury Neurology, PLLC, and its staff (collectively, the “Practice”) to use, disclose, and obtain my Personal Health Information (defined below).**

*Authorization for the Practice to Use, Disclose, or Obtain Personal Health Information*

I understand that this Authorization relates to the use, disclosure, and obtaining of my Personal Health Information. It is intended to satisfy the legal requirements of the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d) (“HIPAA”) and state privacy laws. I hereby authorize the Practice to use, disclose, and obtain my Personal Health Information for the purposes described herein.

*Description and Purposes of Using/Disclosing/Obtaining Personal Health Information*

The information covered by this Authorization (the “Personal Health Information”) includes all information that identifies me that relates to my diagnosis, treatment, payment, criminal record information, healthcare services, continuing care plans, demographic information, treatment progress, and assessment. It includes all information that HIPAA defines as Protected Health Information.

*Authorization for Specific Types of Personal Health Information*

I hereby authorize the Practice to use, disclose, and obtain my entire health record, including HIV test results, genetic screening test results, substance abuse records, sexually transmitted disease records, and mental health diagnosis/treatment records.

**Initial:** \_\_\_\_\_

*Persons to Whom the Practice is Authorized to Disclose My Personal Health Information*

I hereby authorize the Practice to disclose my Personal Health Information to, and obtain my Personal Health Information from, the following persons/organizations (collectively referred to as the “Recipient(s)“):

Person/Organization	Name/Contact Information
Primary care physician	
Medicine or surgery specialist	
Psychiatrist	
Psychologist	
NP’s and PA’s	
Rehab specialists	
Social worker	

I understand that Personal Health Information disclosed to the Recipient(s) may be subject to re-disclosure by the Recipient(s) and it may not be possible to protect the privacy of this information once the Practice discloses it. I release the Practice and its employees from any liability arising from the re-disclosure of this information by such Recipients.

**Sudbury Neurology, PLLC**  
Authorization To Use, Disclose, or Obtain  
Personal Health Information

I understand that the purpose of using, disclosing, or obtaining this information is to improve assessment and treatment planning, to share information relevant to treatment, to coordinate treatment services, to improve health care operations, and assist in billing for payment of services.

Unless I have specifically requested in writing that the disclosure of information be made in a certain format, I understand and agree that the Practice reserves the right to disclose information as permitted by this Authorization in any manner that it deems to be appropriate and consistent with applicable law.

*My Rights*

By signing below, I acknowledge that I have read this Authorization and understand that:

- I may refuse to authorize the disclosure of the above healthcare information. My refusal may result in improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance, or other adverse consequences. The Practice will not condition my ability to receive healthcare services or treatment on providing or refusing to provide this authorization.
- I may revoke this Authorization at any time, either orally or in writing, by notifying the Practice's Privacy Officer at (917) 587-0730 or by email at [jhainsworth@sudburynecuro.com](mailto:jhainsworth@sudburynecuro.com). Revoking this authorization will not apply to information that was already used/disclosed/obtained in reliance on my having signed this form.
- The health information that is disclosed pursuant to this Authorization may be subject to re-disclosure by recipient, and it may not be possible to protect the privacy of this information once re-disclosed.
- I have the right to make a written request to review my records before signing. I have the right to receive copies of my records for a reasonable fee.
- I have a right to a copy of this signed Authorization.

This Authorization will remain in effect until I revoke it, until my treatment relationship with the Practice ends, or until the following date (if filled in): \_\_\_\_\_, 20\_\_.

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**I have read, understood, and agree to the terms of this Authorization.**

\_\_\_\_\_  
Signature of Patient  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_

**If the Patient is incapable of entering into a contract for any reason:**

\_\_\_\_\_  
Signature of Guardian/Custodian  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Nature of Relationship: \_\_\_\_\_

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Psychiatrist	
Psychologist	
NP’s and PA’s	
Rehab specialists	
Social worker	

I understand that Personal Health Information disclosed to the Recipient(s) may be subject to re-disclosure by the Recipient(s) and it may not be possible to protect the privacy of this information once the Practice discloses it. I release the Practice and its employees from any liability arising from the re-disclosure of this information by such Recipients.

**Sudbury Neurology, PLLC**  
Authorization To Use, Disclose, or Obtain  
Personal Health Information

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Signature of Guardian/Custodian  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Nature of Relationship: \_\_\_\_\_

**Sudbury Neurology, PLLC**  
**Notice of Privacy Practices**  
Privacy Officer – Jeffrey Hainsworth, D.O.  
admin@sudburyneuro.com  
(351) 228-4928

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

Sudbury Neurology, PLLC (the “Practice”), provides neurology services.

When you receive care from the Practice, we will create an electronic patient record. The patient record has information about your medical and/or mental health history and status, your treatments, and your progress.

**Who Will Follow This Notice?**

- The Practice and your individual provider(s)
- All other members of the Practice’s workforce

**Summary of Our Uses and Disclosures**

We may use and share your information without your consent to:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
- Get a list of those with whom we’ve shared information.
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us by email at [admin@sudburyneuro.com](mailto:admin@sudburyneuro.com) or by phone at (351) 228-4928.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## **Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We have no plans to share your information for the following purposes, but be assured that we will never do so without your written permission:

- Marketing purposes
- Sale of your information
- Research

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective 8/11/2025.

### Patient Acknowledgment of Receipt

I am a patient of Sudbury Neurology, PLLC (the "Practice"). I acknowledge that:

- I have received the Notice of Privacy Practices (the "Notice") from the Practice.
- I have been provided an opportunity to review it.
- I have asked any questions that I have about the Notice, and the questions have been answered to my satisfaction.
- I fully understand the Notice and agree to its terms.

\_\_\_\_\_  
Signature of Patient

Name: \_\_\_\_\_

Date: \_\_\_\_\_

#### If the Patient is incapable of entering into a contract:

\_\_\_\_\_  
Signature of Guardian/Custodian

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Nature of Relationship: \_\_\_\_\_

Effective 8/11/2025.

## Sudbury Neurology, PLLC

### Consent for Treatment

I, the undersigned, voluntarily seek and consent to treatment by Sudbury Neurology, PLLC ("Practice"). I understand that all treatment by the Practice is voluntary and that I may stop treatment at any time. I have been informed of the nature of the treatment, the benefits and risks of the treatment, and alternative approaches for care. I understand that it is my responsibility to inform the Practice if there are any unexpected changes in my condition or if any problems arise relating to my treatment.

I agree not to take pictures of or record (by any means including, without limitation, audio or video) my treatment without the express written permission of the Practice.

*My signature and date below are provided to evidence that I have read and understand the Practice's Consent for Treatment.*

*By signing this Consent for Treatment, I hereby give informed consent for the treatment recommended by the Practice under the terms and conditions described herein, and I verify that:*

- I fully understand the potential benefits, potential risks, and any practical alternatives to the treatment recommended by the Practice.
- I have had the opportunity to fully discuss the treatment with my provider and all my questions, if any, have been answered to my satisfaction.

\_\_\_\_\_  
Signature of Patient

Name: \_\_\_\_\_

Date: \_\_\_\_\_

#### **If the Patient is incapable of entering into a contract for any reason:**

\_\_\_\_\_  
Signature of Guardian/Custodian

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Nature of Relationship: \_\_\_\_\_

**Sudbury Neurology, PLLC**  
**Telehealth Informed Consent Agreement**

**Introduction.** Telehealth is healthcare provided by any means other than a face-to-face visit. Telehealth services are conducted interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services. **By law, patients must be located in Massachusetts for all telehealth appointments.**

**Patient Acknowledgments.**

- **I understand** that telehealth services will be billed in the same manner as a regular office visit.
- **I understand** that all electronic medical communications carry some level of risk. For example, it is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge.
- **I agree** that I will use a communications system on a secure network that cannot be accessed by employers, friends, or other unauthorized parties, and to protect myself from unauthorized use of my electronic communications by others. I release Sudbury Neurology from all responsibility for breaches of confidentiality caused by me or by an unauthorized third party.
- **I agree** that my healthcare information may be shared with other individuals for scheduling and billing purposes.
- **I agree** to verify my identity and current location at the start of telehealth services.
- **I agree** not to use electronic communication for emergencies or time-sensitive matters.
- **I understand** that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease.
- **I agree to** accept responsibility for following my healthcare provider's recommendations.
- **I agree** to engage in telehealth services despite the possibility of a technological problem or interruption.

**Sudbury Neurology, PLLC  
Telehealth Informed Consent Agreement**

**Sudbury Neurology Patient Statement of Agreement**

*My signature and date below are provided to evidence that I have read and understand Sudbury Neurology's Telehealth Informed Consent Agreement in its entirety. I have had the opportunity to ask questions, and my questions (if any) have been satisfactorily answered.*

*By signing this Telehealth Informed Consent, I hereby give informed consent for the use of telehealth in my medical care under the terms and conditions described herein, and I verify that:*

- I have read and fully understand the information provided above regarding telehealth, including its potential benefits, potential risks, and any practical alternatives.
- I have had the opportunity to fully discuss the information contained herein with my provider and all my questions have been answered to my satisfaction.
- I will be located in Massachusetts while receiving telehealth services.
- **I accept all the terms set forth in this document.**

\_\_\_\_\_  
Signature of Patient  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_

**If the Patient is incapable of entering into a contract:**

\_\_\_\_\_  
Signature of Guardian/Custodian  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Nature of Relationship: \_\_\_\_\_

# Sudbury Neurology, PLLC

## Operating Protocols, Hours, Payment and Communication Standards

Last Updated: 8/17/2025

We are honored that you have enrolled as a member of Sudbury Neurology, PLLC (“Sudbury Neurology”). Your health is invaluable, and with that in mind, Sudbury Neurology is committed to providing you with excellent clinical care, delivered with an approach that optimizes the benefits that result from a personalized doctor-patient relationship.

It is important that you carefully review our operating protocols, hours, communication standards, and payment policies which are provided below. **Please initial the document where indicated and include your signature and date of signature on the last page.** Thank you!

### I. Hours of Operation

#### A. Regular Business Hours and Non-Standard Availability

- Regular Business Hours: Monday – Thursday: 8:00 am – 4:30 pm; Friday: 8:00 am – 2:30 pm
- Non-standard/extended hours: Occasionally, we may offer appointments outside regular hours. Please check with the office for availability.
- Our phones are not monitored outside Regular Business Hours. Calls will be directed to our answering service.

#### B. Holidays and Closures: Sudbury Neurology observes the following public holidays:

- New Year’s Day – January 1
- Martin Luther King Jr. Day – Third Monday in January
- Washington’s Birthday (Presidents’ Day) – Third Monday in February
- Memorial Day – Last Monday in May
- Juneteenth National Independence Day – June 19
- Independence Day – July 4
- Labor Day – First Monday in September
- Columbus Day – Second Monday in October
- Veterans’ Day – November 11
- Thanksgiving Day – Fourth Thursday in November
- Day After Thanksgiving
- Christmas Day – December 25

### Patient Acknowledgment:

- *I understand Sudbury Neurology’s standard business operating hours.*
- *I agree to make an effort to reach Sudbury Neurology during normal business hours.*
- *I understand that contact on major holidays, nights, and weekends will be for urgent needs only. Non-urgent requests will be managed following the next/immediate business day.*

**Initial:** \_\_\_\_\_

# Sudbury Neurology, PLLC

## Operating Protocols, Hours, Communication Standards, and Payment

### II. Adult Appointments (Sudbury Neurology does not treat minors)

Patients are seen by appointment only. Please have your contact information and any past medical records available for your initial visit. Your consent and authorization will be required to review previous records.

At Sudbury Neurology, PLLC, we are committed to providing high-quality, timely care to all patients. To support this commitment, we kindly request that cancellations or rescheduling requests be communicated to the office at least 48 hours in advance. This allows us to offer the appointment to other patients and maintain timely access to care.

- Cancellations made less than 48 hours in advance may be subject to a **\$50 No Show/Cancellation fee**. You are responsible for this fee even if you do not receive a reminder.
- No-shows or late cancellations that occur more than 3 times in any 12-month period may result in discharge from the practice.

We appreciate your cooperation in helping us provide timely and high-quality care for our patient community.

#### Appointment Lengths:

- New Patient: 60 minutes
- Established Patient: 30–60 minutes
- Virtual Established Patient: 15–30 minutes
- Procedure (e.g., Botox, Nerve Block, Skin Biopsy): 15–30 minutes

Please Note: Established patients are those who have been seen in an outpatient setting within the past 3 years.

#### Patient Acknowledgment:

- *I understand that Sudbury Neurology only sees patients by appointment.*
- *I am aware of, understand, and will comply with Sudbury Neurology's cancelled appointments policy.*

**Initial:** \_\_\_\_\_

# Sudbury Neurology, PLLC

## Operating Protocols, Hours, Communication Standards, and Payment

### III. Payment and Fee Schedule for Self-Pay Patients

We currently accept Aetna, Harvard Pilgrim Health Plan (Point32), Humana, Medicare (Parts A & B), Tufts Health Plan (Commercial – Point32), Mass General Brigham Health Plan, and Wellpoint. We have signed our provider agreement with Blue Cross Blue Shield of Massachusetts and are awaiting our Welcome Letter to confirm our in-network status. Until that letter is received, BCBS services cannot be billed as in-network.

We also anticipate accepting MassHealth in the future. Once approved, MassHealth will be accepted on a case-by-case basis, typically requiring provider approval and limited scheduling availability.

- A. Payment: Payment is due at the time of service and may be made via Debit Card or Credit Card.
- B. Credit Card on File: Patients must keep an active credit card on file. Outstanding balances will be charged to the card after 60 days. Balances more than 90 days overdue may be referred to a collections agency. Failure to pay your balance may result in discharge from the practice.
- C. Responsibility to Update Billing Information: It is the patient's responsibility to notify the practice of any updates to credit card information, billing address, or other billing details.
- D. Currently, the fee schedule for self-pay patients is as follows:

<b>New Patient</b>	<b>Established Patient</b>
60 minutes = \$700.00	40 minutes = \$465.00
45 minutes = \$525.00	30 minutes = \$350.00
30 minutes = \$350.00	20 minutes = \$230.00
	10 minutes = \$115.00

#### **Patient Acknowledgment:**

- *I understand that Sudbury Neurology requires payment at the time of service and I will comply with that policy.*
- *I will provide Sudbury Neurology with an active credit card or the necessary credit card information and understand the circumstances that will result to charges to that card.*
- *I agree to provide Sudbury Neurology with updated billing information, card information, and billing addresses.*
- *If I am self-pay for any services provided by Sudbury Neurology, I understand and agree to the fee schedule for new and established patients.*

**Initial:** \_\_\_\_\_

# Sudbury Neurology, PLLC

## Operating Protocols, Hours, Communication Standards, and Payment

### IV. Communication Standards

Address: **Sudbury Neurology PLLC**  
144 North Road, Suite 2200  
Sudbury, MA 01776  
Telephone: (351) 228-4928  
Fax: (351) 500-1656  
Email: Support@sudburyneuro.com

Our preferred method of communication is MGB Epic Patient Gateway secure messaging, which will be available beginning with our clinic's MGB EPIC Go-Live on Thursday, 9/18/2025. Non-urgent emails and phone messages are typically responded to within **3 business days**.

Sudbury Neurology PLLC's email (support@sudburyneuro.com) is HIPAA-secure and may be used only for administrative purposes, such as:

- Scheduling coordination (e.g., follow-up after imaging or testing)
- Submitting or receiving forms (e.g., RMV, FMLA)

Please do **not** use email for medical questions, medication requests, or any other clinical information. These messages will not be addressed by email. For all clinical needs, please use **Patient Gateway** (beginning 9/18/2025) or call the office directly.

By using email for administrative purposes, you acknowledge that while our system is secure, your personal email account may not be. If you cannot use Patient Gateway, please contact us by telephone or mail. Email from a patient directly to their provider is prohibited.

#### A. Health Emergencies and Urgent Situations:

- **Emergencies** (overnight or life-threatening): In the event of a health emergency, please call 9-1-1 or go to your nearest emergency room. If possible, also notify Sudbury Neurology PLLC.
- **Urgent** but non-emergency situations: Contact Sudbury Neurology PLLC. If you call outside regular business hours, your call will be directed to our answering service, which can reach the on-call neurologist for urgent matters. If you do not receive a prompt reply and your condition requires attention, please seek care at an urgent care facility.
- All other situations: If you do not receive a response within 3 business days of contacting the Practice, please try another method of communication (phone, patient gateway, or email) to ensure your message is received.

#### B. Medication Refill Requests

You can request a refill by phone or through secure patient messaging. Please allow up to 3 business days for us to process your request and send it to your pharmacy. To help us handle your refill quickly, please include:

- Medication name
- Dose
- How often you take it.
- Days' supply.

Providing this information helps us avoid delays. Example: *Gabapentin 300 mg by mouth twice daily, 90-day supply.*

#### **Patient Acknowledgment:**

**Sudbury Neurology, PLLC**  
**Operating Protocols, Hours, Communication Standards, and Payment**

- *I will try to communicate with Sudbury Neurology via Patient Gateway.*
- *I am aware of and understand the available communication options and ways to contact Sudbury Neurology, and the relative risks of each.*
- *I understand and accept the risk of communicating with Sudbury Neurology outside of these HIPAA-compliant methods.*
- *I consent to being contacted by Sudbury Neurology at the email address and phone number that I have provided to Sudbury Neurology.*

**Initial:** \_\_\_\_\_

**Sudbury Neurology Member Statement of Agreement**

*My signature and date below are provided to evidence that I have read and understand Sudbury Neurology's Operating Protocols, Hours, Communications Standards, and Payment Policy in its entirety. I have had the opportunity to ask questions, and my questions (if any) have been satisfactorily answered. I accept all of the terms set forth in this document.*

**I have read, understood, and agree to the terms of this Authorization.**

\_\_\_\_\_

Signature of Patient:

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**If the Patient is incapable of entering into a contract for any reason:**

\_\_\_\_\_

Signature of Guardian/Custodian

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Nature of Relationship: \_\_\_\_\_