Neurological & Spinal Surgery, L.L.C.

Patient Information Sheet

(PLEASE PRINT AND USE DARK INK)

PATIENT NAME First:____________ Middle Initial________ Last:____________

Address______________________ **PREFERRED PHONE:** (   ) ____________

City________ State______ Zip__________ **ALTERNATE PHONE:** (   ) ____________

Age________ Birthdate______________ Sex______ Social Security (   )-(   )-(   )

EMAIL______________ @______________ LANGUAGE (if other than English)__________

RACE: White______ African American ______ Asian ______ Hispanic ______ Other__________

PATIENT EMPLOYER______________________ **WORK PHONE** (   )____________

Spouse's Name______________ His/Her employer______________________

PRIMARY INSURANCE______________________ **NAME of POLICYHOLDER** ____________

Phone (   )______________ ID #__________ Group #__________

Policyholder's S.S. ______-______-______ **Policyholder's BIRTHDATE**______________

SECONDARY INSURANCE______________________ **SUBSCRIBER/POLICYHOLDER** ____________

Phone (   )______________ ID #__________ Group #__________

Policyholder's S.S. ______-______-______ **Policyholder's BIRTHDATE** ______________

CONTACT PERSON:____

Name — Phone number — Relationship

_____ **YES** _____**NO** I give the physicians/staff of NSS permission to discuss my medical information with this individual

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Neurological & Spinal Surgery, L.L.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation fees, and court costs. I hereby authorize Neurological & Spinal Surgery, L.L.C. and its employees and agents TO RELEASE ALL INFORMATION, reports, and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors. If I have a liability injury, I understand that I have the option of using my health insurance, if available, or I will be expected to pay for treatment.

A copy of Neurological and Spinal Surgery's **Notice of Privacy Practice Policy**, which describes how health insurance information may be used or disclosed is available upon check in at my appointment or at **www.neurologicalandspinalsurg.com**

A copy of Neurological and Spinal Surgery's **FINANCIAL POLICY** is on the back of this page **PLEASE READ IT.** My signature indicates the above information is correct to the best of my knowledge & that I understand and accept Assignment of Benefits, Neurological & Spinals Surgery LLC's Privacy and Financial Policies, & authorize release of my medical information as outlined above.

Patient or Guarantor Signature:______________________ **Date:**__________

OVER

NEUROLOGICAL AND SPINAL SURGERY, LLC
FINANCIAL POLICY

Thank you for choosing Neurological and Spinal Surgery, LLC. The following is a statement of our Financial Policy. All patients must accept our financial policy guidelines before receiving treatment. Please understand that full payment of your bill is considered a part of our treatment.

REGARDING YOUR INSURANCE: As a courtesy to you, we will submit medical claims to your insurance company. **Any balance after the processing of our claim by your carrier is your responsibility.** You will receive a statement for your balance. A $5 statement fee will be assessed after your 5th statement. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. It is your responsibility to know your insurance benefits. Your insurance may not cover all of the services provided to you.

WHEN SURGERY/ PROCEDURE IS RECOMMENDED: You will be contacted by our staff prior to your procedure to discuss pre-payment on your **ESTIMATED** out of pocket costs and help you make payment arrangements if necessary. If your procedure is elective, a minimum of **50%** of your estimated responsibility is due prior to your procedure. We will give you our best estimate based on the recommended procedure and the information received from your insurance company although actual balance may vary. For procedures with a 90 day global period there will be no charge for follow-up visits during the 90 days following your procedure. This does not apply to radiological services.

SELF-PAY PATIENTS: You will be required to pay a pre-determined down payment at time of service for office visits based on the type of service; consultation, new patient visit or established visit. You will be balance billed if the actual charge is higher than the required pre-payment. Financial arrangements must be made prior to any other services including a minimum down payment of 1/3 of the total estimated charges for radiology and surgical procedures. There may be additional charges based on the actual procedure. Discounts are available for full payment of the estimated amount prior to your procedure. If there are additional charges you will be balance billed at the discounted rate.

WORKERS COMPENSATION: All workers compensation visits must be authorized before your visit or you will be held responsible for payment at time of service. You must provide us with the Workers Compensation Carrier information including name of carrier, address, phone number, contact person, claim number and date of injury. If your claim has not yet been accepted by work comp we can bill your health insurance, if available, but you will be responsible for any unpaid balance.

PERSONAL INJURY: We do not bill attorneys or wait for settlements. You will need to use your health insurance if available or you will be considered self-pay. If using your health insurance you will be responsible for payment of all copays, deductible and coinsurance amounts. You can also use medical payments from your auto insurance if available.

COLLECTIONS: We reserve the right to forward your account to a collection agency if it is determined to be uncollectible. An administrative fee will be applied to your account if it is turned over to collections.

DEFINITIONS below are defined by your health insurance plan and are the financial responsibility of the patient or guarantor:
Copayment: A fixed dollar amount set by your insurance contract that is to be paid at the time of office visit.
Deductible: An annual dollar amount established by your insurance plan that is deducted from insurance benefit.
Coinsurance: A percent set by your insurance plan that is deducted from insurance benefits up to a determined amount. Usually 10% - 30%.
Guarantor: Person responsible for the debt of a minor or other person for which they are the legally assigned guardian.

revised 4/1/15