NeurosurgicalCare

PATIENT REGISTRATION FORM

Welcome to our practice!

Today's Date: _____/____/_____

Please complete this form in order to ensure proper billing of your services.

Patient Name:_____ SSN:_____
Last Name First Name MI Date of birth:___/____/_____
Address:_____ Sex: __ Male __ Female _
City, State, Zip:_____ Marital Status: __ Single _ Married _ Widowed
Home Phone: (____)_____-_____Cell Phone: (____)_____-_____ __ Divorced __ Separated
May we contact you at work? __ Yes __ No Work Phone: (____)_____-_____
May we leave a message containing protected health information on your __ Home Phone __ Cell Phone __ Work Phone?
Race/Ethnicity: _____ Preferred Language: _____
Email address: _____

Please complete this section only if someone other than the patient is financially responsible. The Guarantor is the person financially responsible for this patient's bill.

Guarantor: _____ Patient's relationship to Guarantor: _____
Address: _____ SSN: _____-_____-_____
City, State, Zip: _____ Date of Birth:_____/_____/_____
Phone #: (___)_____-_____ Sex: __ Male ___ Female

Emergency Contact Information:

Name: _____ Patient's relationship to Emergency Contact: _____
Phone #: (___)_____-_____ Alternate Phone# _(___)_____-_____
May we discuss protected health information with your Emergency Contact? ___Yes___No.

Employment Information:

Employment status: __ Employed _ Retired _ Disabled _ Unemployed _ Self-employed _Active military __Student
Employer: _____ Phone #: (____)_____-_____

Insurance Information:

PRIMARY CARRIER:	Phone#
Address:	ID/Cert #
City, State, Zip:	Group/Plan #
Subscriber's name:	Subscriber's DOB:
Relationship to Patient:	Effective Date:
SECONDARY CARRIER:	Phone#:
Address:	ID/Cert #:
City, State, Zip:	Group/Plan #:
Subscriber's name:	Subscriber's DOB:
Relationship to Patient:	Effective Date:

Primary Care Physician/ Referring Physician

PCP:	Referring Physician (if different):
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone #:	Phone #:

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SUPPLEMENTAL MEDICAL HISTORY FORM

Make sure that you have filled-in the bubbles in the Health History Form prior to answering the questions below. Please note that marking a ☑or an ☒ in the bubble is **NOT** sufficient for electronic data entry.

Name: _____ Height: _____ Weight: _____
Please list any medication allergies you are aware of and the type of allergic reactions:
_____
_____

Reason for your appointment: (e.g. neck and arm pain or back and leg pain). Please describe your symptoms, their duration and possible causes (e.g. work- related injury, MVA, etc.)
_____
_____
_____
_____
_____

Conservative Treatment Prior to Office Visit: Check all that apply, and please provide a detailed description (e.g. physical therapy 2-3 times per week for 3 months, or bed-rest for past 2 weeks)

Physical Therapy:
_____
Bed Rest: _____
Cervical Collar: ____Lumbar Brace: ____ Duration and frequency _____
Chiropractic Care: _____ Name of Chiropractor: _____
Epidural Steroid Injection: ___ Number of injections: Date of last injection_____
Name of Pain Management Doctor: _____
Pain medications:
_____
Did you get relief from any of the above measures? _____
If so, how long did the relief last? _____

Medical History:
Please list any medical problems or surgeries you have had that were not included in the bubble history form.

_____
_____
_____
_____
_____
_____

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Patient Medication List

Please list below **ALL** medications you are currently taking. Enter the name of each medication, the dosage (i.e: how many milligrams) and the frequency (how many times a day you take each medication). In addition, please include the date you started taking the medication.

Medication	Dosage	Frequency	Date Started	Date Stopped

Please provide the name and phone number of the pharmacy where your prescriptions are filled.

Pharmacy Name: _____

Pharmacy Phone Number:_____

Patient Name: _____ Date: _____

Patient Signature: _____

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PATIENT NAME (First and Last): _____
DATE OF BIRTH (Required): _____

ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES of Neurosurgical Care, LLC.

SIGNATURE: _____ DATE:_____

* If person signing is not the patient, please print your name and relationship to patient:

NAME: _____

RELATIONSHIP: _____

For Office Use:

INABILITY TO OBTAIN ACKNOWLEDGMENT

No acknowledgment of receipt of Privacy Practices was obtained from the patient because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify): _____

Efforts taken to try to obtain the acknowledgment: _____
_____

SIGNATURE: _____ DATE:_____
(Of Neurosurgical Care, LLC representative)

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RELEASE AND ASSIGNMENT

Date:_____

To: _____
INSURANCE COMPANY

Group No.:_____ Certificate No.:_____

I hereby authorize Dr. _____ to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Basic Medical, Major Medical and/or Surgical treatment or services by reason of such treatment or services rendered to:

_____
PATIENT NAME

_____
SIGNATURE OF INSURED

_____
ADDRESS

_____
WITNESS

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Patient Financial Policy:

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, Mastercard, and American Express. WE DO NOT ACCEPT DISCOUNT CARDS

Do I Need A Referral?
If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Which Plans Do You Contract With?
Medicare/Railroad Medicare/PA Blue Shield/Premier Blue/Blue Choice/Personal` Choice / Keystone Health Plan East/InterCounty/Aetna- (HMO and PPO Plans)/CIGNA/Clear Care/Choice Care/(Humana)/United Healthcare/ First Health/Health Assurance/Health America/CCN (Coventry Health Care)/Devon Health Services/Multi-Plan/NPN/PHCS/Preferred Care/Workmen's Compensation and Auto Insurance (with appropriate claim information)

If you are covered by any of these carriers, it is necessary for you to provide our office staff with the required information that enables us to bill your carrier. In some circumstances even participating insurance plans may leave a balance that you must pay. It is **not** our responsibility to know what limitations, exclusions, deductibles or copays each group insurance plan might leave to a patient's responsibility.

Your doctor may participate with other insurance plans not listed above. Please check with the practice office staff to see if your insurance plan will be accepted

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable co-pays is requested at the time of the office visit. If the services you receive are not covered by the plan: Full payment is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you. File an insurance claim on your behalf.
HMO & PPO plans with which we are not contracted.	Full payment due at the time of office visit. Insurance will *not* be accepted for office charges for non-participating insurance plans	Provide a receipt that includes all of the necessary information for you to complete and file your claim directly with the insurance company

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If You Have...	You Are Responsible For...	Our Staff Will...
Point of Service Plan or Out Of Network PPO	Full payment of the patient responsibility portion due at the time of the visit. (including deductible, co-pay, non-covered services)	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services. File an insurance claim on your behalf.
Medicare	Assignment of Medicare claims does not mean that Medicare pays your entire bill. Patient's responsibility on assigned Medicare claims includes payment of: --Annual Medicare deductible (currently $135.00) --20% co-insurance on approved services --Non-covered services --Services rendered under a waiver of liability, approved, but not paid by Medicare <u>If you have Regular Medicare as primary, and also have secondary insurance or Medigap</u>: No payment is necessary at the time of the visit. <u>If you have Regular Medicare as primary, but no secondary insurance</u>: Payment of your 20% copay is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Worker's Compensation /Auto / General Liability Insurance	<u>If we have verified the claim with your carrier</u> No payment is necessary at the time of the visit. <u>If we are not able to verify your claim</u> Payment in full is requested at the time of the visit.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

Inpatient and/or Nursing Facility Procedures:

If your physician recommends surgery, you will be escorted to his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Surgery Coordinator.

If an inpatient service or office diagnostic /surgical procedure is performed, we will file an insurance claim as a courtesy to our patients. After 30 days if payment has not been received, the balance will be transferred to your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, co-insurance, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You as the insurance policy holder are responsible for the timely payment of your account.

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What if My Child Needs to See the Physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

Delinquent Accounts
An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency.

Missed Appointments
We would appreciate your help and the courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty four (24) hours prior to the appointment time. We reserve the right to charge a missed appointment fee for each appointment that is not canceled in a timely manner.

Return Check Fee:
There will be a transaction fee of $15 for any check that is returned for insufficient funds.

I hereby acknowledge that I have been provided with, read, and understand the patient financial policy stated above and agree to be subject to same.

I certify that the insurance information provided by me is correct. I authorize any holder of medical or other information about me needed for this or a related claim to release it to my insurer or its agents.

I request that the payment of authorized benefits be made on my behalf. I assign benefits payable for services of Neurosurgical Care to be paid to Neurosurgical Care.

I authorize Neurosurgical Care to submit a claim to my insurer(s) as may be required. I understand that I am responsible for deductibles, coinsurance charges and co-payments not covered by my insurance. Should my insurance plan not provide coverage in its entirety for any reason, I understand that I may be responsible for payment.

_____	_____	_____
Date	**Signature**	**Printed Name**

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NeurosurgicalCare

CANCELLATION/ "NO SHOW" POLICY FOR APPOINTMENTS AND SURGERY

We understand that you may need to cancel your appointment and/or your surgery due to unavoidable circumstances. As a courtesy to our healthcare professionals and to other patients, please notify us of your cancellation as soon as possible. ***When you do not call to cancel an appointment or a procedure in a timely fashion, you may be preventing another patient from receiving care…***

Cancellation/ "No Show" Policy for Appointments

Your appointment time is reserved especially for you. Should you find that you are unable to keep your appointment, please notify our office at least 24 hours in advance. This will allow us to offer your appointment slot to another patient. \

- If you fail to show up for your appointment, a $50.00 fee* will be charged to your account. The same applies to appointments canceled with less than 24 hours notice.

  * This fee is not covered by insurance and must be paid in full prior to rescheduling the missed appointment.

- We understand that extenuating circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived subject to management approval.

- Patients who schedule and fail to keep three (3) appointments in the span of one year may be dismissed from the practice for "treatment noncompliance".

Cancellation/ "No Show" Policy for Surgery

Due to the large block of time reserved for your procedure, last minute cancellations can create access-to-care problems, as well as, significant expenses for the office. If you need to cancel your surgery, please notify our office at least 10 days in advance.

- If you fail to show up for surgery, or if surgery is not cancelled at least 10 days in advance you will be charged a $150 fee*.

  * This fee is not covered by insurance and must be paid in full prior to rescheduling your procedure.

- We understand that extenuating circumstances may cause you to cancel less than 10 days prior to your scheduled procedure. Fees in this instance may be waived subject to management approval.

- Patients who cancel the same procedure twice may be dismissed from the practice for "treatment noncompliance".

Please direct any questions regarding the Cancellation/ "No Show" Policy for Appointments and Surgery to **Kristy Schugsta, Billing Coordinator at (610) 495-3620 #120**.

Please sign that you have read and understand the Cancellation/ "No Show" Policy for Appointments and Surgery.

Patient Name:_____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____
or Patient Representative