SOUTHWEST NEUROSCIENCE AND SPINE CENTER, PA

NEW PATIENT INFORMATION

DATE:_____

First Name MI Last Name	Sex		Marital Status					Date of Birth	Social Security No.
	M	F	S	M	W	D	SEP		
Mailing Address	Zip Code		City and State						Home Phone No.
E-mail Address	Occupation (Indicate if Student)							Cell Phone No.	Business Phone No.
Patient's Employer	Responsible Party/Spouse							Responsbile Party/Spouse Address/Zip Code	
Responsible Party/Spouse Employer	Resp. Party Phone No.							RP/spouse Date of Birth	Social Security No.

Emergency Contact (Not living in the same household)	Relationship to Patient	Phone Number
Referring Physician & Address	If not referred by a physician, who is your PCP?	

Primary Insurance Company: _____

Secondary Insurance Company: _____

Are you being seen for injuries sustained in a Motor Vehicle Accident? Yes No

Are you being seen for injuries sustained from an on the job injury? Yes No

IF YES

DATE OF INJURY _____ TREATING PHYSICIAN _____

EMPLOYER AT TIME OF INJURY _____ ADJUSTOR NAME/PH # _____

Filing Your Insurance

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company.

Agreement as to Governing Law and Forum:

The patient and health care provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas District Court in the county where all or substantially all of the health care was provided or rendered an in no event will any lawsuit, action or cause of action ever be brought in any other state or in any Federal Court. The choice of law and forum selection provisions of this paragraph are madatory and are not permissive.

SIGNATURE_____ **DATE**_____

I WILL BE PAYING TODAY BY: CASH:_____ CHECK:_____ CREDIT CARD: _____

Southwest Neuroscience and Spine Center, P.A.

Notice of Privacy Practices

This notice describes how Medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At our facility, privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you when necessary to provide treatment, verify eligibility and obtain authorization about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principals.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name, address, and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Also, in order to remind you of appointments or changes in appointments we may leave a message with someone in your household or answering machine either at home or place of employment. From time to time, we may send information via US Mail regarding appointments, follow-up, or other health information.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please contact the office manager at this clinic. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practice and procedures.

How-and why-information is shared

We limit who receives information and what type of information is shared.

- Sharing information within our organization. We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- Sharing information with companies that work for us. To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

Acknowledgement of Receipt of Notice of Privacy Practices

I _____ acknowledge that I have received a copy of this practice's Notice of Privacy Practices. This Notice describes how this practice may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

_____ _____

Signature of Patient, or Personal Representative *Date*

_____

Relationship to Patient

SOUTHWEST
NEUROSCIENCE
& SPINE CENTER

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____, authorize the following people access to my medical records.

Name	Phone Number
_____	_(____)_____
_____	_(____)_____
_____	_(____)_____
_____	_(____)_____
_____	_(____)_____
_____	_(____)_____
_____	_(____)_____

_____ _____

Patient Signature Date

P.O. Box 51690 • AMARILLO, TX 79159 • 11 Medical Drive, Amarillo, TX 79106 • (806) 353-6400 • FAX (806) 358-2662

FINANCIAL POLICY

Southwest Neuroscience & Spine Center

Welcome to Southwest Neuroscience and Spine Center. We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

PARTICIPATING PROVIDER

We are providers for a select group of major PPO networks and the Medicare program. However, due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. **Therefore, it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list *before* making an appointment.** You will be responsible for payment in full for services rendered by your physician if he/she is not a provider in your plan. We will try our best to inform you of changes in our provider status as they occur.

For Non-PPO plans or traditional "80/20" plans, we will file a claim as a courtest, however, the contract with your insurance company is between you and the company. Southwest Neuroscience and Spine Center is not a party to that contract. You are ultimately responsible for your bill, regardless of any non-payment by the insurance carrier. If within 45 days, payment is not received by your insurance company; payment will be due by you, regardless of the status of your claim.

CO-PAYMENTS

We require your co-payment at the time of service. The co-payment specified on your card will be collected. If the co-pay amount is not listed on your card, or you have a standard "80/20" plan, we will collect 20% of the services rendered.

YOU MUST PRESENT A VALID INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.

DEDUCTIBLE

If you have a deductible, and it is likely that the services rendered will go toward your deductible, payment in full must be made at the time of service.

REFERRALS

If your insurance requires a referral it should be very specific stating the exact services and number of visits authorized. It is your responsibility to keep track of the number of remaining referrals.

PRECERTIFICATION OF HOSPITAL ADMISSION OR SPECIAL SERVICES

Precertification of hospital admissions and other special services is an area we strive to help you with. With the exception of some HMO plans, it is ultimately the patient's responsibility to inform us when precertification is a requirement of your plan. Due to the varying policy provisions of all of our patient's plans, it is impossible for us to know each patient's specific plan provisions. **If you fail to disclose precertification requirements PRIOR to services being rendered, you will be responsible for payment of all related fees in full.**

FOR OUTPATIENT AND INPATIENT SERVICES PROVIDED OUTSIDE OF OUR OFFICE, IT IS YOUR RESPONSIBILITY TO BE AWARE OF AND INFORM US OF WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN. THIS INCLUDES X-RAY, LABORATORY, DIAGNOSTIC AND REHABILITATION FACILITIES.

SECONDARY INSURANCE

We will file secondary insurance as a courtesy to you. Please keep in mind that payment of your account is ultimately your responsibility, and we will look to you for payment of your account if we are unsuccessful in obtaining reimbursement by your insurance.

LIABILITY OR AUTO ACCIDENT CLAIMS

Our physicians treat automobile accidents or liability type cases on a limited basis. We will file the claim to insurance. We do not wait on settlement to be paid. You will be required to pay in full for services rendered.

RESPONSIBLE PARTY (GUARANTOR)

The guarantor of the account is the patient who comes in for treatment or the adult who brings in a minor for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings a minor child in, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of Southwest Neuroscience to become involved in medical bill payment disputes resulting from divorce, etc.

WORKERS COMPENSATION CLAIMS

If you have been injured on the job, we require that you provide us with all of the information necessary to file a worker's compensation claim. You MUST provide the name, address and phone number of your employer, the name, address and phone number of the worker's compensation carrier, the exact date of injury, and verification from your employer that a valid on the job injury occured. If you are unable to provide us with this information on your FIRST visit or if workers comp determines it is non-compensable or not work related, you will be required to pay in full at the time of service.

SCHEDULED APPOINTMENTS.

If you must cancel or reschedule an appointment please notify our office at least 24 hours in advance. We reserve the right to charge a "No Show" fee of $50.00. Patients that do not show up for a scheduled visit three times and do not cancel or reschedule the appointment in advance will be dismissed from the practice.

BILLING OF ACCOUNT BALANCES

You will receive a statement for which payment is **due upon receipt**. If your statement reflects an "insurance balance" you claim is still pending payment. If you statement reflects a "patient balance", this is the portion for which you are responsible. We strongly recomment your active involvement in the management of your account. When you receive your statement, compare it with your insurance explanation of benefits to ensure that the balance is correct. If payment has not been received by your insurance company, contact them. In this way, we can work together to ensure insurance companies honor their part of the agreement.

PAYMENT PLANS

We understand that from time to time unexpected circumstances may arise which makes paying for medical care difficult. With this understanding, we provide payment plans to assist you in the management of your account. You may contact a patient account representative at 806-353-6400 to arrange for this service. This practice will accept cash, checks, credit cares and/or EFT.

NSF CHECKS

We utilize the services of **ReCheck** for any NSF items received. Once returned, these items are handled directly by **ReCheck**. When we receive 2 NSF checks on your account, we will accept only cash for future visits.

NON-PAYMENT OF ACCOUNTS

Accounts for which we are unable to collect the balance due will be referred to an outside collection agency. We also reserve the right to report this activity to a national credit-reporting agency. Each physician reserves the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

ACCEPTANCE OF FINANCIAL POLICY

The undersigned hereby certifies that he/she has read, understood and agrees to the financial policy of Southwest Neuroscience and Spine Center.

_____ _____

Signature of Patient or legal Guardian **Date**

ASSIGNMENT OF BENEFITS

The undersigned hereby requests that payment from authorized insurance carrier or state benefits program be made directly to the Southwest Neuroscience and Spine Center physicians who rendered servicees on their behalf. The undersigned also releases the disclosure of medical information for use in obtaining reimbursement by an authorized insurance carrier.

_____ _____

Signature of Patient or legal Guardian **Date**