

# Welcome To Neurosurgical Associates, L.L.P.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First Middle Last

Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Cellular/Mobile Phone: ( ) \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Email Address: \_\_\_\_\_ May send information here? Yes No  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_

*Complete this section only if someone other than the patient is financially responsible.  
(Parent information, if patient is a minor)*

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer's Telephone: ( ) \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Requesting Consultation: \_\_\_\_\_  
Phone: \_\_\_\_\_

Location: \_\_\_\_\_



# Financial Policy

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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, or MasterCard.

## 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?

Please contact your individual insurance company for contractual agreements.

## 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...                                     |
|---|--|---|
| <b>Commercial Insurance</b><br>Also known as indemnity, "regular" insurance, or "80%/20% coverage." | Payment of patient responsibility for all office visits, x-ray, injection, and other charges at the time of office visit.  | File an insurance claim as a courtesy to you.         |
| <b>HMO &amp; PPO plans with which we have a contract</b>  | <u>If the services you receive are covered by the plan:</u><br>All applicable co-pays and deductibles are requested at the time of the office visit.<br><br><u>If the services you receive are not covered by the plan:</u> Payment in full is requested at the time of the visit. | File an insurance claim on your behalf.               |
| <b>HMO with which we are <u>not contracted.</u></b>   | Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.   | File an insurance claim on your behalf as a courtesy. |
| <b>HMO with which we are <u>not contracted.</u></b>   | Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.   | File an insurance claim on your behalf as a courtesy. |
| <b>Point of Service Plan or Out Of Network PPO</b>  | Payment of the patient responsibility—deductible, co-pay, non-covered services—at the time of the visit.   | File an insurance claim on your behalf as a courtesy. |

| If You Have...                | You Are Responsible For...  | Our Staff Will...   |
|-------------------------------|---|---|
| <b>Medicare</b>               | <p>If you have Regular Medicare, and have not met your \$100 deductible, we ask that it be paid at the time of service.</p> <p>Any services not covered by Medicare are requested at the time of the visit.</p> <p><u>If you have Regular Medicare as primary, and also have secondary insurance or Medigap:</u><br/>No payment is necessary at the time of the visit.</p> <p><u>If you have Regular Medicare as primary, but no secondary insurance:</u><br/>Payment of your 20% co-pay is requested at the time of the visit.</p> | File the claim on your behalf, as well as any claims to your secondary insurance.                             |
| <b>Medicare HMO</b>           | All applicable co-pays and deductibles at the time of the office visit.   | File the claim on your behalf, as well as any claims to your secondary insurance.                             |
| <b>Worker's Compensation</b>  | <p><u>If we have verified the claim with your carrier</u><br/>No payment is necessary at the time of the visit.</p> <p><u>If we are not able to verify your claim</u><br/>Payment in full is requested at the time of the visit.</p>  | Verify information given by referring physician and file your claim on your behalf as a courtesy.             |
| <b>Motor Vehicle Accident</b> | All charges incurred will be the responsibility of the patient. Please make arrangements with our business office for payment prior to seeing the doctor.   | <b>We will not bill third party insurance companies, such as PIP.</b>   |
| <b>No Insurance</b>           | Payment in full at the time of the visit.   | Work with you to settle your account. Please ask to speak with our billing supervisor if you need assistance. |

### 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.

### Surgery Policy

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.

The Business Office may request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Business Office.

**Consent for Purposes of Treatment, Payment and Healthcare Operations (HIPAA)**

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I consent to the use or disclosure of my protected health information by Neurosurgical Associates, LLP for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Drs. Baldwin, D’Alise or Smith may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Neurosurgical Associates, LLP is not required to agree to the restrictions that I may request. However, if Neurosurgical Associates, LLP agrees to restriction that I request, the restriction is binding on Neurosurgical Associates, LLP and each physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Neurosurgical Associates, LLP and Drs. Baldwin, D’Alise or Smith have taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Neurosurgical Associates, LLP’s notice of Privacy Practices prior to signing this document. Neurosurgical Associates, LLP’s Notice of Privacy will be provided to me by the receptionists at my request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Neurosurgical Associates, LLP. The Notice of Privacy Practices for Drs. Baldwin, D’Alise or Smith is also provided at 3601 21<sup>st</sup> St, Lubbock, TX 79410. This notice of Privacy Practices also describes my rights and Neurosurgical Associates, LLP’s duties with respect to my protected health information.

Neurosurgical Associates reserves the right to changes the privacy practice that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I consent Neurosurgical Associates, L.L.P. employees disclosing my private health information such as test results and billing information with a designated family member or personal representative.

\*YES \_\_\_\_\_ NO \_\_\_\_\_

\*If yes, please designate the person to whom such information may be disclosed (note: can be more than one):

Patient’s Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient or Self