Patient Balance:
Physician:

NEUROSURGERY of St. Louis

PATIENT INFORMATION

Last Name:		First Name:		M.I.	
Address:		City:		State/Zip:	
Home Phone:		Cell:		Marital Status:	
Social Security #:		Date of Birth:		Gender:	
Employer/Occup:		Employer Phone:		**PATIENT #:**	

➔ **Email:** _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

OTHER INFORMATION

Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____

AUTHORIZATION

I hereby authorize this office to furnish information to insurance carriers concerning this illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or workers compensation. I hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing healthcare services to me. If I fail to obtain a referral, I understand that I am financially responsible. I acknowledge that I have received the mandatory information regarding "Notice of Privacy Practices." (HIPAA)

X SIGNATURE: _____ **Date**: _____

AUTHORIZATION TO RELEASE INFORMATION *(Your Signature is Required)*

Do You Authorize Another Person To Receive Your Medical Information? Yes □ No □

If YES, Who _____ Relationship to Patient _____

Do You Authorize Another Person To Receive Your Billing Information? Yes □ No □

If YES, Who _____ Relationship to Patient _____

Do You Authorize Neurosurgery of St. Louis to Leave Patient Test Results on an Answering Machine or Voice Mail: Yes □ No □ If YES, at which phone number(s)? _____

X SIGNATURE:_____ **Date**: _____

Neursurgery of St. Louis complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Patient Name:

Date of Birth:

NEUROSURGERY of St. Louis

Financial Policy - Payment and Insurance

Health Insurance Information - a copy of your insurance card(s) is required

PRIMARY COVERAGE:

Insurance Company Name: _____ Subscriber (circle one): Self Other

If subscriber is not patient, name of subscriber: _____ Date of Birth: _____

SECONDARY COVERAGE:

Insurance Company Name: _____ Subscriber (circle one): Self Other

If subscriber is not patient, name of subscriber: _____ Date of Birth: _____

- Please contact your insurance company to make sure Neurosurgery of St. Louis is a participating, in-network provider on your plan prior to scheduling an appointment. Some plans may require you to obtain a "referral" from your primary care provider prior to seeing a specialist. If your insurance requires a referral, we will not be able to see you until you obtain that.
- We can still help you even if we are not a participating, in-network provider with your insurance. Your insurance coverage will be determined by any "out of network" benefits you may have as dictated by your plan.
- Applicable copayments will be collected at the time of service. This arrangement is part of our contract with your insurance company, and our failure to collect copayment from you may be considered fraud.
- We will collect any unmet deductible and applicable patient payment responsibility at the time of your visit.
- Fees for services not covered by insurance are collected at the time of visit.
    - If further fees are owed after adjudication of the insurance claim, you will receive a monthly statement.
- Patients who do not have insurance coverage or have a Health Savings Account / Health Reimbursement Arrangement will be required to pay in full at every visit.
- For your convenience, our office accepts cash, debit cards, credit cards (MasterCard™ VISA™, and Discover) and personal checks. We may only allow payment plans in limited circumstances.
- Please contact your insurance plan representative if you have questions regarding coverage for your visit or procedure. Insurance companies are responsible to you, the policyholder, not to the physician. As a courtesy to you, our office will file your claims to your insurance company as long as we are "contracted" with your insurance company. However, we do not determine the amount of coverage

you will receive. Your insurance company determines the amount of your coverage and you should be aware of your benefits prior to all office visits and procedures. Any questions you may have concerning your insurance benefits should be directed to your insurance plan representative. You are ultimately responsible for the payment of all charges.

- For your convenience we will file your claim with your insurance but we must have accurate information at the time of your visit. Claims that are denied for payment because of incorrect information will become the responsibility of the patient. It is very important to let us know immediately of any change in your insurance information. We do file primary and secondary claims but do not file claims to tertiary insurance policies.
- No show appointments or appointments cancelled with less than 24 hour notice will be charged $30 per incident. A fee of $75 will be charged for scheduled procedures such as CT scans, X-rays and Urodynamics Studies cancelled without a 72 hour notice.
- A fee of $150 will be charged for **elective surgeries** cancelled less than 5 days in advance, unless cancelled for medical reasons. The fee may also be charged if you request that your surgery date be rescheduled. Rescheduled surgeries create significant additional work for our staff.
- Please contact our Billing Office at 833-684-0015 should you have any questions.

I have reviewed the Neurosurgery of St. Louis Financial Policy and agree to comply with its guidelines.

_____ _____

Patient or Guarantor Signature **Date**