# Woodlands Neurology Clinic

***PATIENT NAME:*** _____ DATE: _____

**FINANCIALLY RESPONSIBLE PARTY**

Name: First_____ MI_____ Last_____

Relationship: Spouse Parent Guardian Other (Please specify): _____

Address: _____Apt #_____

City_____ State _____ Zip _____

Home Phone_____ Cell_____ Work_____

Patient Email Address _____

Employer: _____

***Please bring your insurance card and ID with you to your visit.***

***OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS***

☐ Do Not Release Information

I authorize Woodlands Neurology Clinic and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Woodlands Neurology Clinic of changes or update. I authorize Woodlands Neurology Clinic to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship_____

Phone_____

You may release the following information to the person named above:

☐ Appointments ☐ Billing Information ☐ Medical Care/Test results ☐ Leave Message

Signature _____ Date_____

***EMERGENCY NOTIFICATION***

Name: _____ Relationship to Patient: _____

Home phone _____ Cell_____ Work_____

## FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

**Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.**

- I authorize direct payment of my insurance benefits to Woodlands Neurology Clinic for services rendered to myself or dependents.
- Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian.
- I understand that it is my responsibility to know my insurance benefits and whether the services rendered are covered benefits.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
- Services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
- Woodlands Neurology Clinic or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.

**Lab / X-Ray / Diagnostic Services:**

- I understand that I may receive a separate bill if my medical care includes labs, imaging such as MRIs or CTs, or any other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.
- I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.

Patient Name _____ Signature _____ Date_____

## ***CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS***

- I consent to treatment necessary to the care which has been discussed and directed by the provider.

- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment.

- I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

- I further authorize and request that insurance payments be directed to Woodlands Neurology Clinic

I have read, fully understand and agree to the above medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment and release of medical information & insurance authorization. I also certify that all the information, provided is complete and accurate.

Patient Name _____

Signature _____ Date_____

## ***PRIVACY PRACTICES***

Our office, physician, and staff are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices. You can either download this notice from our website at https://www.woodlandsneurologyclinic.com, or ask us to print a copy for you.

Signature_____ Date _____

# Woodlands Neurology Clinic- Office Policies

Thank you for choosing Woodlands Neurology Clinic! We are committed to providing you with the superior medical care with a time efficient and cost-effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

Please initial at the beginning of each line:

_____ **Insurance: The patient is responsible for knowing their insurance benefits and if you have a deductible or copayment.** If you have an **HMO policy, you are responsible for obtaining the referral prior to your visit**. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account. For commercial insurances, we will not file claims to a secondary insurance. We can provide you with a billing summary so you can file the claim.

_____ **Check-in**: **For new patient appointments, please arrive about 60 minutes** before appointment time, so that all paperwork as well as the check in process may be completed before your appointment time. **If you have your paperwork filled out, please still arrive 30 minutes prior to your appointment time. If you arrive at your appointment time without completed paperwork, you may be asked to reschedule.**

_____ **Late arrivals:** We do our best to keep to the schedule. When a patient arrives late it is impossible to stay on schedule. **If you arrive more than 15 minutes late you may be asked to reschedule your appointment** so that other patients are not inconvenienced.

_____ **Medication list**: Please bring an updated medication list to include the names of prescriptions, dose and frequency, or your medication bottles to each appointment. To avoid medication errors, it is essential that we be able to confirm your current medications.

_____ **Dishonored checks:** A $30 service fee will be assessed on all dishonored checks. The full amount of the check written plus $30 must be paid by cash or credit card.

_____ **Prescriptions:** It is the patient's responsibility to call our office or contact us through the patient portal five days prior to running out of medication. **Refills may take between 2 - 4 business days to be processed.**

_____ **Forms/letters:** A $25 fee will be charged for forms completed by provider or any detailed letters requested from the physician.

I have read, understood, and agree to the above office and financial policies.

Patient name: _____

Signature: _____ Date: _____

# Woodlands Neurology Clinic
# Cancellation/No show and Procedure Policies

Our goal is to provide quality individualized medical care in a timely manner. Late cancellations and no Shows (this includes arriving more than 15 minutes late) create inconvenience and prevent scheduling of other patients who need access to medical care in a timely manner. We understand situations arise when you may need to cancel your appointment and we appreciate advance notice when that happens. This helps us be respectful of other patients needs and enables us to give the appointment time to another patient who needs to see us.

## Office Appointments

_____ Please call our office at least 24 hours (Monday - Friday) prior to your scheduled office appointment to notify us if you need to reschedule or cancel the time that was reserved for you. Office appointments which are rescheduled or cancelled without 24 hours notice will be subject to a **Late Cancellation/ No show Fee**. The fee will be $50 for the first occurrence and is subject to increase based on the number of occurrences. This fee will not be submitted to insurance. It is your responsibility and must be paid in full prior to scheduling your next appointment. If your appointment is on Monday morning at 9:00 or Tuesday through Friday at 8:30, your appointment must be confirmed by NOON the business day before or it will be a late cancel and subject to the late cancellation fee.

## Procedures: EMG/NCS and EEGs

_____ **A $100.00 Deposit** will be requested to schedule a procedure. This deposit is applied to the cost of the procedure. If the deposit is not needed toward the cost, and you keep your appointment, you will receive a refund. Please call our office at least 24 hours (Monday - Friday) prior to your scheduled office appointment to notify us if you need to reschedule or cancel the time that was reserved for you. If you fail to keep the appointment, or cancel the appointment without giving appropriate notice, no refund will be given. You will be required to place another deposit to reschedule.

**Thank you for your understanding.** We appreciate being able to care for you. We understand there can be special unavoidable circumstances which may cause you to cancel with short notice. Please let us know if this happens.

I have read, understood, and agree to the above policies.

Patient name: _____

Signature: _____ Date: _____