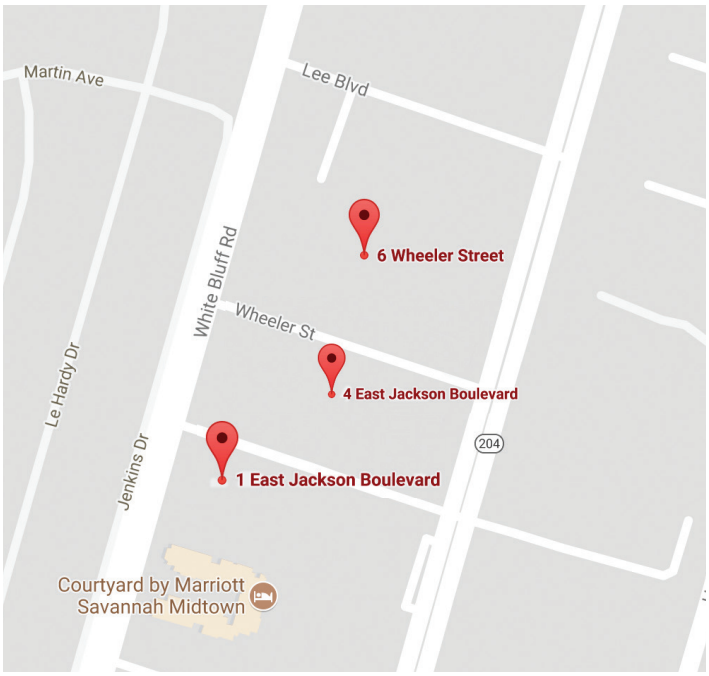
Neurological & Spine Institute

DIRECTIONS



The Neurological & Spine Institute Imaging Center
X-Ray, MRI, CT & Lab
6 Wheeler Court

The Neurological & Spine Institute
Doctors' Offices
4 E Jackson Blvd.

The Neurological Institute Ambulatory Surgery Center
Outpatient Surgery & Injections (additional parking)
1 E Jackson Blvd.

FROM I-16

- Stay on I-16 to 516 toward Savannah heading East.
- Take Exit 164A; this street will turn into Derenne Ave.
- Turn right onto Abercorn St.; Jackson Blvd. will be the 4th traffic light.
- Turn right onto Jackson Blvd.

FROM I-95

- Turn onto GA Highway 204.
- Take Exit 94 (Abercorn Expwy. to Abercorn St.).
- Continue on Abercorn St. for approximately 12 miles.
- Turn left onto Jackson Blvd.

FINANCIAL POLICY

The Neurological and Spine Institute is committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, however, we need your assistance and your understanding of our financial payment policy.

1. **Financial Policy**
   a. Self-pay patients are expected to pay for services received in full at the time of service. Any financial arrangement must be made before you see the physician. We accept the following forms of payment: cash, check, American Express, MasterCard, Visa and Discover.

   b. **As a courtesy to you, we will file your insurance claim form for reimbursement.** However, in order to do this, we must have current insurance information. Charges not paid by your insurance company within 90 days will become due and payable by you. Patients who do not provide current insurance information will be treated as self-pay (see above).

   c. If your insurance plan requires a referral or authorization from your primary care physician, we will need to receive the authorization number before you see our physicians. If you are unable to obtain the authorization, you can sign a medical waiver and pay us directly for the services we provide you, and we will refund you when we receive the proper authorization for those services.

   d. Surgical procedures will require a deposit, including deductibles, co-payments and coinsurance. Payment of these amounts are required at the time of scheduling you for your procedure.

   e. Parents, a designated family member, or legal guardian are responsible for payment for services rendered to children.

   f. We will bill for Workers' Compensation services that have been authorized by your employer or Workers' Compensation insurance carrier.

   g. We charge additional fees as outlined below:
   - Insurance or Disability forms
   - CD Copy
   - Medical record review
   - Medical deposition

   h. Please be aware that any balance on your account over 90 days is subject to collection procedures and may result in denial of future care until overdue balances are paid in full.

   i. We provide advanced imaging services (i.e. MRI & CT) as part of our practice for the convenience of our patients. However, please be advised that you have the right to obtain the above services at a provider of your choice. A list of alternative providers of advanced imaging services is as follows:

Coastal Imaging Center
503 Eisenhower Dr.
Savannah, GA 31406
912-355-6255

St. Joseph's/Candler Imaging Services
105 Grand Central Blvd., Suite 106
Pooler, GA 31322
912-748-0068

Any and all Actute Care Hospitals

Pooler Imaging
136 Traders Way
Pooler, GA 31322
912-330-5170

Trident Medical Imaging (CT only)
627 Stephenson Ave.
Savannah, GA 31405
912-355-7523

Open MRI/Savannah (MRI only)
4815 Waters Ave.
Savannah, GA 31404
912-355-6736

Effingham Hospital
613 Towne Park Loop (MRI only)
912-826-6015
110 Goshen Rd. (CT only)
912-826-1400
Rincon, GA 31326

PATIENT INFORMATION FORM

PATIENT INFORMATION MINOR SINGLE MARRIED DIVORCED WIDOWED

NAME _____ MALE FEMALE

LAST MI FIRST

ADDRESS_____

CITY _____ STATE _____ ZIP _____ HOME PH ( ) _____

OTHER PH ( ) _____ DATE OF BIRTH ___/___/___ SOCIAL SECURITY # _____

RACE: ☐American Indian/Alaskan Native ☐Black/African American ☐White ☐Hispanic/Latino ☐Hawaiian/Pacific

EMAIL _____ EMPLOYER _____ PHONE ( ) _____

GENERAL INFORMATION

Who referred you to our office? (Doctor/Friend/Internet) _____ PHONE ( ) _____

Nearest relative (not living with you) _____ PHONE ( ) _____

In case of emergency notify: _____

RELATIONSHIP _____ PHONE ( ) _____

SPOUSE/PARENT INFORMATION

NAME _____ MALE FEMALE

LAST MI FIRST

PHONE ( ) _____ DATE OF BIRTH ___/___/___ SOCIAL SECURITY # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ OTHER PH ( ) _____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN _____ POLICY HOLDER'S NAME _____

ID# _____ GROUP# _____ PHONE ( ) _____

SECONDARY INSURANCE PLAN _____ POLICY HOLDER'S NAME _____

ID# _____ GROUP# _____ PHONE ( ) _____

IS VISIT DUE TO: ☐Auto Accident ☐Worker's Comp. DATE OF ACCIDENT ___/___/___

CLAIM# _____ BILLING ADDRESS _____

HIPPA INFORMATION Instructions for the office when returning phone calls or reminding you about appointments.

I authorized the office to contact me at ☐Home ☐Work ☐Cell

The office may leave a message at ☐Home ☐Work ☐Cell

I authorized the office to leave detailed messages about appointments/phone calls ☐Yes ☐No

Patient (or Parent/Guardian) Signature _____ DATE ___/___/___

PATIENT HEALTH HISTORY

NAME _____ DATE OF BIRTH ___/___/___
LAST MI FIRST
HEIGHT _____ WEIGHT _____
PREFERRED PHARMACY _____ PHONE ( ) _____
PHARMACY ADDRESS _____
CITY _____ STATE _____ ZIP _____

CURRENT MEDICATION(S)	DOSE	FREQUENCY

ALLERGIES TO MEDICATIONS/OTHER

Are you taking Coumadin? ☐Yes ☐No
Are you taking Glucophage? ☐Yes ☐No
Have you ever had problems with anesthesia? ☐Yes ☐No
Are you allergic to IVP, X-Ray or Contrast Dye? ☐Yes ☐No

TREATMENT & MEDICATION AGREEMENT

The purpose of this agreement is to promote understanding about certain medicines you may be prescribed or may already be taking. This is to help you and your physician comply with the law regarding prescription drugs. This agreement is essential to the trust and confidence necessary in the physician/patient relationship.

The use of narcotic medications has inherent risks with adverse effects including chemical dependency, addiction, CNS depression, hypotension, seizures, constipation, nausea, vomiting, dizziness, headache, confusion, respiratory arrest, somnolence, coma and death. Narcotic medication alone, or in combination with muscle relaxants, sleeping pills, anxiety medications, antihistamines, decongestants, or alcohol can cause cognitive impairment and delayed reaction time.

These guidelines are in place for your safety and well-being. Our hope is that you consider that pain medicine is provided as adjunctive therapy and not as long term management of symptoms while under neurological care.

Please read carefully before signing

1. **I will receive medications from one prescribing physician only.** This means, if you are obtaining medications (pain meds/muscle relaxants) from your following physician, or from ER physicians, you are to continue receiving medications from their office. If our physician assumes your care, and at any time you obtain the above listed medications from any other physician, our physician reserves the right to discontinue further prescriptions for you.

2. **I will not share, sell, or trade my medications with anyone.**

3. **Lost or stolen medicines will not be replaced.** Once the prescription is in your trust, it may not be refilled until time allowed.

4. **Medicine will be refilled Monday through Friday from 9:00am to 4:00pm. No refills will be available during weekends, evenings, or holidays.**

5. **I will use my medicine at no greater rate than prescribed.** A greater rate will result in my being without medicine for a period of time.

6. **I understand that if I am pregnant or become pregnant while taking opioid medications**, my child could become physically dependent on opioid medications, and withdrawals can be life threatening for a baby.

7. If at any time I break the law with regards to my pain medicine, I am aware that the appropriate **law enforcement department may be notified and my records could be released to them.** It is illegal to sell, trade, or share prescription medication. It is illegal to obtain controlled substances from more than one doctor without telling the other doctor. It is illegal to obtain alter or fabricate prescriptions.

8. If I break this agreement, my doctor may stop prescribing these pain control medicines and, if recommended, submit to an evaluation by an addictionologist, or discharge if necessary.

The acceptance of this document authorizes the physician and your pharmacy to cooperate fully with any city, state, or federal law enforcement agents, including this state's Board of Pharmacy in regards to the actions listed above. I authorize the physician to provide a copy of this agreement to my pharmacy.

This agreement has been reviewed and signed on the _____ day of _____ in the year of _____.
PATIENT NAME _____ PATIENT SIGNATURE _____
PHARMACY _____

PAYMENT AGREEMENT

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account. I accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance covers these services. I agree to pay within 60 days of receipt of notice all balances due such as non-covered services, coinsurance, deductibles and co-payments not paid by my insurance company.

I, _____ , HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPT THIS FINANCIAL POLICY AND PAYMENT AGREEMENT.

SIGNATURE _____ DATE ___/___/___

Responsible/Authorized Representative (Guarantor) _____

Relationship to Patient _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ , hereby authorize The Neurological & Spine Institute together with its employees, agents and contractors, to use or disclose my protected health information (covered under Privacy and Security Regulations to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) as specified in this authorization. I understand that protected health information includes my medical and billing information and other records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health diagnosis, treatment or related communications, or information relating to diagnosis, testing or treatment for AIDS, HIV, or other communicable diseases (collectively referred to herein as "PHI")).

Recipient(s) of Use or Disclosure
This information may be used by or disclosed to names listed below and its subsidaries, employees, agents and contractors.

Information to be Used or Disclosed
I understand the information to be enclosed shall include all information in my medical record unless specific items have been submitted in writing.

Expiration
This authorization will remain in effect until a written notice is provided to The Neurological & Spine Institute.

Revoking Authorization
I understand that I may revoke this authorization by submitting a written request for revocation to The Neurological & Spine Institute, provided that such revocation shall not be effective with respect to any use or disclosure made in reliance on this authorization prior to the date of The Neurological & Spine Institute receipt of my revocation.

Authorization as a Condition to Treatment
I understand that The Neurological & Spine Institute cannot require me to sign this authorization in order to receive medical treatment from them.

Potential Re-Disclosure
I understand that the PHI used or disclosed by The Neurological & Spine Institute pursuant to this authorization may be subject to re-disclosure by the recipient who may or may not be subject to the HIPAA Privacy Rule and may not be subject to other state or federal privacy laws.

Compensation
I understand that I will not receive compensation from the recipient for the use/disclosure of my PHI. I understand that The Neurological & Spine Institute will not receive compensation for the disclosure of my PHI.

NAME _____
LAST MI FIRST

AUTHORIZED NAME LIST

_____ _____
NAME RELATION

_____ _____
NAME RELATION

_____ _____
NAME RELATION

_____ _____
NAME RELATION

(If additional space is needed please attach additional pages.)

I also give The Neurological & Spine Institute staff permission to leave a message at:

PHONE ( ) _____ INITIAL _____

I have read and understood this authorization and my questions have been answered. I certify that I am the patient listed above or a person authorized to permit release of records on the patient's behalf. I hereby release The Neurological & Spine Institute and recipient and its officers, trustees, employees, agents and contractors from any liability arising in connection with the use or disclosure of my protected health information pursuant to this authorization. I understand that if this authorization is being requested by The Neurological & Spine Institute they must provide me with a copy of the signed authorization.

PATIENT SIGNATURE _____ DATE ___/___/___

Print Patient's Authorized Representative Name _____
Signature of Patient's Authorized Representative _____
Basis of Authority to Sign for Patient _____

MEDICAL RELEASE AUTHORIZATION

NAME _____ DATE OF BIRTH ___/___/___

LAST MI FIRST

ADDRESS_____

CITY _____ STATE _____ ZIP _____

SSN OR MEDICAL RECORD # _____ PHONE ( ) _____

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following facility/physician may receive disclosure of protected health information about me:

   The Neurological & Spine Institute, Dr._____

   ADDRESS: 4 E Jackson Blvd., Savannah, GA 31405

   PHONE: ( ) _____ FAX: ( ) _____

2. Effective Period: this authorization for release of information covers the period of healthcare from:
   ___/___/___ to ___/___/___
   OR
   ☐ all past, present, and future period

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION _____

NO, DO NOT DISCLOSE THIS INFORMATION _____

SIGNATURE _____ DATE OF SIGNATURE ___/___/___

DATE OF BIRTH ___/___/___ SOCIAL SECURITY # _____

OR if applicable

SIGNATURE OF GUARDIAN/RESPRESENTATIVE _____

DATE OF SIGNATURE ___/___/___ DESCRIPTION OF AUTHORITY TO ACT FOR INDIVIDUAL _____