FRONTIER NEUROSCIENCES

Referring Provider: _____ Primary Care Provider: _____

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: ____

Birth date: _____ Age: _____ SSN:_____

Sex: M F Marital Status: M S D W Email:_____

Home Address, City, State, Zip: _____

Mailing Address, City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Employer Address: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Local Pharmacy: _____ Mail Order Pharmacy: _____

Primary Ins: _____ Policy Holder: _____

Relationship to Patient: _____ Birth Date: _____ SSN:_____

Secondary Ins: _____ Policy Holder: _____

Relationship to Patient: _____ Birth Date: _____ SSN:_____

RESPONSIBLE PARTY (if different from patient):

First Name: _____ Last Name: _____ Relationship to Patient: _____

Address, City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Employer Address: _____

Birth date: _____ SSN: _____

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PATIENT DISCLOSURE AUTHORIZATION

I hereby give my authorization to disclose my protected health information to the specific individual(s) listed below. Please *initial* all that apply:

_____ It is acceptable for you to leave information on my home/cell answering machine and/or voicemail.

Phone number(s): hm:_____ cell: _____

_____ It is acceptable for you to call my place of employment and leave a message.

Phone number: _____

_____ I do not want you to speak with anyone other than my referring provider (if applicable)

_____ It is acceptable for you to speak with only the following individuals regarding my condition (please *initial* all that apply and provide their names and phone number, if applicable)

_____ Spouse: _____

_____ Parents/Guardian: _____

_____ Siblings: _____

_____ Children: _____

_____ Medical Provider(s): _____

_____ Other: _____

It is the patient's responsibility to notify the office staff of any changes to this Authorization. This authorization is valid for one year of the signature date unless otherwise specified by the patient.

Patient/Responsible Party Signature: _____ Date: _____

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Please read the following and initial:

Assignment of Insurance Benefits: I, the undersigned, hereby assign all medical benefits, to include major medical benefits, private insurance, Medicare, Medicaid, and any other health plans, to which I am entitled, to the office of: Frontier Neurosciences (FNS). In the event payment is made directly to me for services rendered in this office, I recognize the obligation to promptly remit payment to this office.

INITIAL: _____

Responsibility for copay/co-insurance/deductible amounts/pre-auths: We bill most insurance carriers for you provided we are given the proper information. Since my agreement with my insurance carrier is a private one, I understand that FNS does not routinely research why an insurance carrier has not paid. I agree to be fully responsible for paying my copay, co-insurance and deductible amounts, at the time of visit, according to my insurance plan. I understand that it is my responsibility to contact my insurance carrier prior to the time of service, for any pre-authorizations. Even though my insurance may be filed, I understand that all bills are payable upon receipt and that I, not the insurance company, am responsible for payment of all services. Should the account be referred to a collection agency, I shall pay all collection expenses.

INITIAL: _____

SELF-PAY Patients: I agree that in consideration of services to be rendered, I obligate myself to assume financial responsibility and agree to pay in full at the time of service unless prior arrangements have been made. Should the account be referred to a collection agency, I shall pay all collection expenses. All future visits will be paid in full at time of service.

INITIAL: _____

Acknowledgement of Notice of Privacy Practices: I acknowledge I have read and understood the HIPPA Notice of Privacy Practices.

INITIAL: _____

Missed Appointments: In fairness to other patients and the provider, we require at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

INITIAL: _____

Medication Download: I give consent to FNS and Athena Health to download my medication history from my pharmacy into my electronic medical record.

INITIAL: _____ YES _____ NO

Patient/Responsible Party Signature: _____ Date: _____

Payment Policy

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care. This is our payment policy. Please read, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in several insurance plans, including Medicare, Medicaid, BCBS, Cigna, CNIC, and UCH to name a few. We will bill your insurance for you even if we are not participating with them. If you do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and Deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered service. Please be aware that some of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. Our billing system will send you 3 statements and you will receive automated phone calls for 90 days following the posting of a balance to your account. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for your understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**