COASTAL NEUROLOGICAL INSTITUTE, P.C.

PATIENT PAYMENT POLICIES AND PATIENT ASSIGNMENT OF BENEFITS

It is very important for you to read and understand this entire document before signing!

As with any service organization, our financial obligations must be met in order to provide medical services today as well as the new services of tomorrow. We take the responsibility of your medical care very seriously and this includes the accurate billing and payment for only services that are necessary. Because of the shift from the insurance based payment system of the past to the more patient driven payment system of today the issue of payment is often unclear to patients. This shift in payer responsibilities now requires you to play an active role in the billing and payment. Which means it is also your responsibility to know the benefits/coverage of your insurance. Our goal is to answer all of your questions, limit surprises, and most importantly take care of your health.

Financial Policy:

1. Co-pays. Based on your agreement with your insurance carrier we are required to collect your co-pay prior to service. If you are unable to pay your co-pay, co-insurance, or deductible and your insurance requires us to collect at the time of service we will not provide you medical care at CNI until you are able to do so. This is a company policy and not a physician decision. We will not go ask the doctor. We will however reschedule your appointment as previously stated.
2. Claims for services rendered are filed as a courtesy to you. In order for this courtesy to work we must receive the necessary demographic and coverage information from you or the Guarantor of your policy (i.e. spouse) prior to your visit. Otherwise your claim will be denied and the balance for service rendered will become your responsibility to pay at the time of service.
3. All co-pays, deductibles, co-insurance, previous balances, and fees for non-covered services are due at the time of your visit. In the event we are unable to collect your balance within 60 days of the date of service we will turn your account over to one of our collection agencies for collection. Any and all fees associated with the collection of your debt to CNI will be entirely your responsibility in addition to your initial debt. Collection fees can be as high as 33.3% of your total unpaid balance. By signing below you agree to pay your entire debt within 60 days.
4. If you are a Medicare recipient, we will file your claim with Medicare as required. It is your responsibility to notify Medicare of your supplemental insurance. Normally, Medicare will forward your claims to your supplemental carrier for processing co-insurance or deductibles. This does not guarantee your supplement will pay these balances. In the event of nonpayment your supplemental balance will remain the patient's responsibility and payable upon notice from CNI.
5. Services we provide may not be covered by your insurance. We will make every effort to inform you when your insurance company will not cover our services. In the event your insurance company does not cover the services provided by CNI, you will be responsible for these charges. It is your responsibility to know the benefits / coverage of your insurance. Coastal Neurological Institute, P.C. will make every effort to obtain any necessary prior authorizations before a service is performed. However, CNI will not be responsible for any necessary prior authorizations required by your insurance company that were not obtained.

Assignment of Insurance Benefits:

CNI must obtain and maintain a new signature each year to accept assignment of benefits from Medicare or any other insurance entity. By signing below, you authorize your insurer of other payer for services (Medicare, Medicaid, etc.), whether or not specified herein, to make payments directly to the holder (CNI) of this assignment rather that to the undersigned. You recognize that you, separately and / or jointly, remain financially responsible to CNI for any charges

Patient Signature: _____ Date: _____

Patient's Legal Guardian: _____ Date: _____

Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. *PLEASE REVIEW IT CAREFULLY.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. **WHO WILL FOLLOW THIS NOTICE.** This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. **CHANGES TO THIS NOTICE.** We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. **COMPLAINTS.** If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Lacey E. Norrell, Privacy Officer, 251-450-3700 3280 Dauphin Street Bldg A, Mobile, AL 36606. All complaints must be submitted in writing. You will not be penalized for filing a complaint. **OTHER USES OF MEDICAL INFORMATION.** Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by Agreeing below that I have received the **Notice of Privacy Practices and Notice of Individual Rights**

Patient or Guardian Signature:_____ **Date:**_____

COASTAL NEUROLOGICAL INSTITUTE, P.C.

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE Coastal Neurological Institute, P.C. to perform medical treatment.

I CONSENT Coastal Neurological Institute, P.C. to use and disclosure of all individually identifiable personal, health, financial and demographic information (known as Protected Health Information or PHI) for the purposes of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me (messages, reminders)

The above purposes and all other uses are known collectively as Treatment, Payment and Other Healthcare Operations or TPO and this information may include or be related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV related opportunistic infection or pregnancy. You may review or receive a copy of our entire Notice of Privacy practices upon request.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to Coastal Neurological Institute, P.C. when needed for the purpose of TPO.

I CONSENT to Coastal Neurological Institute, P.C. discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV related opportunistic infections or pregnancy with the following personal contact(s) :

1. _____ Relationship: _____ Phone #: _____
2. _____ Relationship: _____ Phone #: _____
3. _____ Relationship: _____ Phone #: _____

I have been given the opportunity to review and agree with the terms and conditions of Coastal Neurological Institute's Patient Information Protection Plan.

I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms and conditions of Coastal Neurological Institute, P.C.'s Patient Information Protection plan, the practice has the right to and will withhold treatment except where required by law.

PRINT PATIENT/GUARDIAN NAME _____

PATIENT/GUARDIAN SIGNATURE _____ DATE: _____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non- healthcare related activities without specific and explicit authorization.

___ By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voicemail or answering system if I am unavailable at the number provided by me.

Medicare Part B

EXTENDED PATIENT SIGNATURE AUTHORIZATION

TO COMPLETED BY PROVIDERS OF SERVICE – Please PRINT or TYPE

Provider's Name (If you are a DME supplier, please complete certification at bottom of page)	Provider's I.D. Code
COASTAL NEUROLOGICAL INSTITUTE, PC	D549

Provider's Address (Street, City, State, ZIP Code)
3280 Dauphin Street Bldg A, Mobile, AL 36606-4060

Beneficiary's Name	Medicare HI number	Applicable MEDIGAP group number

TO COMPLETED BY BENEFICIARY OR AGENT – Directions For Payment Of Benefits And Release Of Medical Information

STATEMENT FOR PAYMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ or to _____. (the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

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STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to _____ for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to (name of MEDIGAP insurer) _____ any information needed to determine these benefits or the benefits payable for related services.

_____
Signature of Beneficiary/or person signing for Beneficiary Date signed

Address of Person Signing For Beneficiary (Street, City, State, Zip Code)	Relationship Of Agent To Beneficiary

Reason Beneficiary Is Unable To Sign

IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment – even those in which the physician has not accepted assignment.
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients: "DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF." This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

IMPORTANT INFORMATION FOR SUPPLIERS

1. Only use the extended patient signature authorization for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement: "RESPONSIBLE FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."

DURABLE MEDICAL EQUIPMENT SUPPLIERS AGREEMENT

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OR DURABLE MEDICAL EOUIPMENT IN ASSIGNMENT CASES.

This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of the return of, or the end of need for the rental of equipment, or the death or institutionalization of the Beneficiary.

_____ _____
Signature of Durable Medical Equipment Supplier Date Signed

PATIENT FORM

PATIENT NAME: _____ D.O.B._____

REASON FOR SEEING DOCTOR: _____ PCP / REFERRED BY: _____

MEDICATION LIST: /	DOSE:	HOW TAKEN:	
			Are you having Difficulty with balance? Y/N
			Do you have episodes with dizziness? Y/N
			Have you experienced blackouts? Y / N
			Falls in the past 12 months? Y / N

PHARMACY: _____ LOCATON/NUMBER: _____

MEDICATION ALLERGIES: _____

SURGERY LIST:

_____ _____

_____ _____

_____ _____

PLEASE CIRCLE: MARRIED / DIVORCED / SEPARATED / WIDOW / SINGLE

DO YOU HAVE CHILDREN: YES / NO NUMBER OF CHILDREN: ____

OCCUPATION: _____ FULL / PART-TIME DISABLED / RETIRED

HEIGHT: _____ WEIGHT: _____ RIGHT / LEFT HANDED