



excellence in brain, spine and pain care
neurosciencegroup

Consent for Treatment, Financial Responsibility, Insurance & Assignment
Informed Consent for Release of Medical Information

Name of Patient: _____ Attending Provider: Neuroscience Group

CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, INSURANCE & ASSIGNMENT

1. I recognize that I have a health care condition requiring provider care and hereby voluntarily consent to the customary examinations, tests, and procedures performed by the provider and to such routine medical treatment as my attending provider or other provider of Neuroscience Group consider to be necessary.
2. I recognize that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment by the provider.
3. I hereby authorize direct payment to Neuroscience Group for authorized benefits of this treatment. I hereby assign the benefits payable for provider services to the provider or organization furnishing this service or authorize such provider or organization to submit a claim to Medicare/my insurance for payment. I understand that I am financially responsible to Neuroscience Group for charges not covered by this assignment.
4. I certify that the information given by me in applying for payment under Medicare/Medicaid or any other insurance plan is correct.

INFORMED CONSENT FOR RELEASE OF MEDICAL INFORMATION

1. *I hereby authorize the provider to release any information from the records of this treatment (including references to treatment of alcohol, drug abuse, emotional illness, developmental disability and HIV testing/AIDS) to my provider(s), my insurance company(ies), the Social Security Administration or its intermediaries or carriers, State and municipal governments or their agencies, or to any other institution or organization providing funds for my medical services. I understand that disclosure will enable the provider to collect payment for services rendered to me during my treatment by the provider and/or enhance the continuity of my care. I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon and will remain in effect for a reasonable time in order to achieve the purpose(s) for which it is given.*
2. *I understand that I (or any other person holding a statement of informed consent signed by me) have a right, upon reasonable notice to the provider, to review my medical record and/or receive a copy of my medical record upon payment to the provider of reasonable costs.*

FINANCIAL RESPONSIBILITY

PAYMENT FOR SERVICES: Patients who are covered under a HMO are required to have a referral and pay the co-pay at the time of service. For uninsured patients, full payment is due at the time of service. All other payments are due in full within 30 days of billing. In the event it becomes necessary to take legal action to collect an account, the patient or other responsible party agrees to pay the Neuroscience Group's costs of collection, including attorney fees.

PAYMENT FOR PROCEDURES: Fees will be billed to your insurance carrier if your insurance information is on file in our office prior to your procedure. If you do not have insurance, we require payment in advance of the procedure. Please be aware that some companies pay a fixed allowance for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance including "usual and customary" left unpaid by your insurance company. We know questions may arise regarding procedures, so please call our business office for information and assistance.

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1305 W. American Drive, Neenah, WI 54956
(920) 725-9373 or (800) 201-1194
www.neurosciencegroup.com

PRIVATE INSURANCE: For your convenience, we will submit claims to all primary and secondary insurance carriers. Please remember that your insurance coverage is a contract between you and your carrier, and we are not a party to your insurance contract. If your carrier has not paid on your claim within 30 days, please contact them. You, the insured, are responsible for payment on any claims that are (1) denied; (2) unpaid due to deductible; (3) partially paid; (4) specifically, partially paid due to the carriers arbitrary determination of "usual and customary" rates.

MEDICARE: To assist our Medicare patients, we submit and accept assignment on all Medicare claims. If you have supplemental insurance and have provided us with the necessary information, we will file that insurance claim as well. Services not covered by Medicare are your responsibility.

WORKER'S COMPENSATION: If you are being treated for a work-related injury, we will submit your claim to the appropriate insurance carrier. To do this, we will need to know the name and address of your employer as well as the name of your employer's worker's compensation insurance carrier. We will also ask for information regarding your health insurance carrier. This is necessary so we may process a claim to your health insurance carrier should worker's compensation deny your work-related claim. Services denied by your worker's compensation carrier are your responsibility.

MEDICAL ASSISTANCE: If you are covered by Medical Assistance, you will need to present an eligibility card at each visit. Your Medical Assistance co-pay is also required at the time of service. If you are covered under a HMO, you are required to have a referral at the time of service.

LITIGATIONS AND DISPUTES: If your claim is involved in litigation and/or being disputed among carriers, please remember you are still financially responsible for services provided to you. Prompt payment is expected.

FOR ADDITIONAL ASSISTANCE: We can assist with your insurance or financial arrangements. Call our business office Monday-Thursday 8 a.m. to 5 p.m., or Friday 8 a.m. to 4 p.m. (920) 725-9373, toll-free (800) 201-1194.

I have read this form and/or it has been fully explained to me, and I certify that I understand its contents and am competent to execute it or authorized to execute it on the patient's behalf.

Patient's Signature

Date Signed

Witness Signature

Location (city or township) Where Signed

If the patient is unable to consent or is a minor, complete the following:

Patient is a minor _____ years/days of age, or is unable to consent because:

Signature of Person Legally Authorized to Give Consent to Patient

Witness Signature

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Neuroscience Group for any services furnished to me. I authorize the release of medical information to the Health Care Financing Administration and its agents for the determination of benefits payable to related services. I understand that this provider accepts Medicare assignment and agrees to accept the charge determination of the Medicare carrier as the full charge and I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based on the Medicare charge determination.

Patient's Signature

Date Signed