

Treating physician: _____

Appointment Date: _____

PATIENT INFORMATION

PATIENT NAME _____ **DATE OF BIRTH** _____

HOME ADDRESS _____

HOME PHONE # _____ **STREET** _____ **TOWN** _____ **ZIP CODE** _____
BUSINESS PHONE # _____

SS# _____ **E-MAIL ADDRESS** _____

EMPLOYER _____ **OCCUPATION** _____

EMPLOYER ADDRESS _____

SPOUSE NAME _____ **DOB** _____ **SS#** _____

EMPLOYER _____ **EMPLOYER PHONE** _____

EMPLOYER ADDRESS _____

EMERGENCY CONTACT _____ **PHONE** _____

PHARMACY NAME AND ADDRESS _____

PHARMACY PHONE# _____ **FAX#** _____

PRIMARY INSURANCE

RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT _____

NAME OF INSURANCE COMPANY _____

ADDRESS _____

ID# _____ **GROUP#** _____ **PLAN#** _____

SECONDARY INSURANCE

RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT _____

NAME OF INSURANCE _____

ADDRESS _____

PHYSICIAN REQUESTING CONSULT _____

ADDRESS _____ **PHONE** _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____ **PHONE** _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

Cause of Injury

Patient Name: _____

To the best of your knowledge, is your condition related to **any type of injury or accident**?

Please provide the following information:

1. Date of injury or accident: _____

2. Complete description of injury or accident: _____

3. Do you plan to file a lawsuit? _____

4. Do you have an attorney involved in your case? _____

5. If so, please provide name, address and phone number of attorney: _____

6. Name, address and phone number of insurance company responsible for payment:

7. Name and phone number of claims adjuster and/or case manager: _____

8. Assigned case or claim number: _____

****Please note that any charges that are denied by your insurance company are your responsibility. DuPage Neurosurgery is unable to withhold patient billing as a result of a litigated status. ****

Patient Signature: _____ Date: _____

Thank you for choosing **DuPage Neurosurgery** as your healthcare provider.

Our goal is to provide outstanding operative and non-operative neurosurgical care to patients with disorders of the brain, spine, or peripheral nerves, as well as to patients who suffer from chronic pain. The following is a statement of our Financial Policy, which we require that you read and sign before treatment.

Please note that DuPage Neurosurgery is contracted with several insurance companies. Please check with our Reception or Billing Staff if you should have questions that directly relate to your insurance carrier.

It is our policy that we have a current photocopy of your insurance card on file. Please be prepared to show your insurance card at every visit.

Co-payments: Co-payments are expected at the time of service and will be collected prior to your visit at check-in.

Non-Contracted Insurance Plans, are considered as Out of Network: Full payment is required at the time services are rendered. (As a courtesy to our patients, we will forward all claims to your insurance company and they will reimburse you directly.)

Motor Vehicle Accident/Third Party Liability: Full payment is required at the time of service regardless of any claim or pending legal action. (As a courtesy to our patients, we will forward all claims to your insurance company and they will reimburse you directly.)

Workers' Compensation: We will file a claim with your employer or its insurance company as long as we have authorization that your injury is being considered a compensable Worker's Compensation claim.

Missed Appointments: In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee for any appointments missed or not cancelled at least 24 hours prior.

Guarantee of Payment: To continue to provide quality service and to keep billing costs under control, it has become necessary to require guaranteed payment of deductibles, co-insurance and co-payments prior to services performed.

For your convenience, we have developed with Visa, Master Card and Discover companies' direct credit card billing, after your insurance company has paid all its benefits in full.

If no deductible, coinsurance or co-payment is required, nothing will be billed to your credit card.

Understanding Credit Card Guarantee of Payment

Billing Process:

- 1) Your insurance company is first billed.
- 2) After insurance payment is received you will be billed for any remaining balance due at the time statements are mailed out. Statements are mailed out on the 15th of every month.

- 3) After you receive a statement in the mail you have 15 days from receipt of statement to make a payment by any method.
- 4) If we do not hear from you or receive payment after 15 days, your credit card will be charged the remaining balance due.

Why?

We had to implement credit card guarantee to keep billing cost down. The way we keep costs to a minimum is by sending you only one statement. Thereafter, we implemented a credit card guarantee system for payment on patient balances.

We hope this is helpful in understanding our policy.

Authorization for Release of Information

I hereby authorize DuPage Neurosurgery, S.C. to release information requested by my insurance company or Worker's Compensation carrier. I also authorize DuPage Neurosurgery, S.C. to release information to any hospital, surgery center, treatment or diagnostic center or physician I may be referred to by this office.

Assignment of Benefits

I hereby represent and agree as follows: a) I represent that I currently maintain medical insurance coverage which will reimburse the charges for medical services provided; b) If my medical insurance is not sufficient to satisfy the charges in full, I acknowledge that the resulting balance is not covered by this assignment and I will be fully responsible for payment of this balance due. In consideration of these medical services, I hereby assign, transfer, and set over to DuPage Neurosurgery, S.C., all of my rights, title and interest to medical reimbursement benefits under my insurance policy (s) and/or any pending or future lawsuits, claims or actions.

Verification of Benefits

I acknowledge that I have provided DuPage Neurosurgery, S.C. with all known insurance information, which may be applicable to help expedite payments. This includes but is not limited to all insurance policies, correct insurance data, and pre-certification information.

Form Completion Policy

DuPage Neurosurgery understands the importance of form completion and we are happy to complete them for you, however, due to the growing number of forms that need to be completed, and time involved, our office has instituted the following policy:

1. There is a \$25.00 fee **per form** that must be paid before the forms will be completed.
2. When forms are completed they will be mailed to the patient's home address.
3. All patient information on forms **must** be completed by the patient before we can process your request.
4. Please allow 5 business days for the completion of each request.

Guarantee of Payment:

I agree, whether I sign as patient or as agent, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay DuPage Neurosurgery, S.C. in accordance to the terms stated in this financial policy.

If you should have any questions, please contact our billing department at (630) 858-5400.

Sign

Date

By signing this I thoroughly understand and agree to the terms of the above stated policy.

Credit Card Guarantee of Payment

Today's Date: _____

Patient Name: _____

Individual authorizing credit card payment: _____

Credit Card #: _____

Type: MC _____ VISA _____ DISC _____

Name as listed on credit card: _____

Exp. Date: _____

Security Code: _____

Card holder's signature: _____

Date: _____

