NEUROLOGICAL SURGERY, P.C

PLEASE FILL OUT IN ITS ENTIRETY

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ________________ Age: ________
Address: ____________________________ City: _________________ State: NY Zip: ________
Home: (____) _____ - _____ Cell: (____) _____- ______ Work: (____) _____- ______ Ext: ___
Email Address: ______________________________________
Sex: □ M □ F Social Security #: ____/ ___/ ____
□ Single □ Married □ Widowed □ Separated □ Divorced
Occupation: ______________________ Employer: ___________________________________
Employer's Address: ____

Referred By: ____ Phone #: (___) _____- _______
Address: ____

Primary Physician: _________________________________ Phone: (____) _____- _______
Address: ____

Preferred Pharmacy Name: ________________________________ Phone: (____) _____- _______
Pharmacy Address: ____

Emergency Contact/ Relationship: ________________________________ Phone #: _______________

INSURANCE INFORMATION

Primary Insurance: ____

Policy Holder's Name: ______________________________ ID #: _________________________________

Policy Holder's Birth Date: _____________________ Policy Holder's SS #: _________________________

Secondary Insurance: ____

Policy Holder's Name: _____________________________ ID#: __________________________________

Birth Date: __________________________ SS#: ___________________ Group #: __________________

WORKER'S COMPENSATION or NO FAULT: *please circle one*

Insurance Company: ____ Date of Accident: _____________

Address: ____

Policy Number: ____ Carrier Case #: ______________________

Case Manager: ______________________________________ Phone #: (_____) ____- _______ Ext: ___

NSPC
Brain & Spine
Surgery

TERMS AND AGREEMENTS

1. You agree to fully cooperate with us in collecting the insurance payment (s) and provide us with a copy of the summary of benefits and coverage for your plan ("summary plan description) if requested. You will be personally responsible for any amounts due to Neurological Surgery, P.C. ("NSPC") that are not covered by your insurance, including amounts that become due as a result of incorrect insurance information. The estimated amount that you will be billed is available upon request.
2. Depending on your health insurance policy, you will be responsible for CO- PAYS and DEDUCTIBLES for office visits or for surgical procedures at NSPC.
3. If the doctor you plan to see is not in your network, and your insurance policy does not allow for out of network benefits, ARRANGEMENTS CAN OFTEN BE MADE FOR YOU TO SEE ONE OF OUR DOCTORS IN YOUR PLAN.
4. If the doctor scheduled to perform your surgery is not in your network but your insurance policy allows out of network benefits, we will consider the amount paid by your insurance policy and the requirements of applicable law in determining the amount of your out of pocket expenses.
5. If you are scheduled for surgery, any of our personnel who are providing necessary services for your procedure in the operating room or participating in your care (for example, physician assistant, co- surgeon, and/ or monitoring team) may be permitted to submit separate bills under the same conditions as above.6.
6. Once your insurance has received and processed your claim, they should send you a statement ("Explanation of Benefits") within 30-45 days. If you have any questions regarding your insurance coverage, we may able to assist you.7.
7. Any legal action or proceedings that may arise between you and NSPC (or any of its subsidiaries, affiliates, or any of their respective shareholders, officers, directors, employees, physicians or other healthcare providers) for any reason related to your care or services from NSPC or its subsidiaries or affiliates, including but not limited to financial disputes and/ or claims related to the quality of care provided by an NSPC provider, shall only be brought in the courts of the State of New York and in the County of Nassau (unless parties agree, in writing, to an arbitration in Nassau County in lieu of such a court hearing). By execution and delivery of this document, the undersigned hereby (i) accepts the jurisdiction of the aforesaid courts, (ii) agrees to be bound by any judgment of any such court with respect to this Agreement; (iii) waives, to the fullest extent permitted by law, any objection which it may now or hereafter have the venue set forth above; and (iv) further waives any claim that any such suit, action or proceeding brought in any such court has been brought in an inconvenient forum.
8. Questions regarding management of any balance can be discussed with the billing department at 516-442-3461.
9. It is not our intent to impose financial hardship. If any of these terms creates a hardship, the Billing Department has flexible terms and will cooperate with you to provide a fair and reasonable financial settlement of your obligations to NSPC.

By signing below you acknowledge that you agree and accept these terms.

Name: ______________________ **Signature:** ______________________

Keep one copy, and return signed copy to NSPC **Date:** ______________________

NEUROLOGICAL SURGERY, P.C

PATIENT COMMUNICATION CONSENT FORM

Patient Name: ____

Date of Birth: __________________________________

I agree to allow NSPC to contact me using the following methods regarding my personal health information, evaluation and treatment. I authorize/ do not authorize NSPC to leave messages for me when I am unavailable as indicated below.

Check to confirm approved method	Method	Phone #/ Address	Messages (Yes or No)
	Home Phone	(____) ____- ______	◻ Yes ◻ No
	Cell Phone	(____) ____- ______	◻ Yes ◻ No
	Work Phone	(____) ____- ______	◻ Yes ◻ No
	Alt. Phone	(____) ____- ______	◻ Yes ◻ No
	Email	(____) ____- ______	◻ Yes ◻ No

I authorize NSPC and medical staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to patient	Contact Information

Emergency Contact Only:

Name: ___________________________________ **Phone Number:** ______________________

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand the risk associated with different methods of communication, especially email, and consent to communications outlined in this consent.

_____________________________________ _____________________________________

Patient Name Printed **Patient/ Authorized Signature**

_____________________________________ _____________________________________

Date **Relationship to Patient**

Participating Insurance Plans

- Medicare
- Workers Compensation
- No Fault
- Cigna
- UHC (Empire Plan/ NYSHIP)

Affiliated Hospitals

- Catholic Health Services (CHSLI) / Good Samaritan Hospital
- Catholic Health Services (CHSLI) / St. Catherine's of Sienna Medical Center
- Catholic Health Services (CHSLI) / St. Charles Hospital
- Catholic Health Services (CHSLI) / Mercy Hospital
- Catholic Health Services (CHSLI) / St. Joseph's Hospital
- Catholic Health Services (CHSLI) / St. Francis Hospital
- Northwell Health/ North Shore University Hospital
- Northwell Health/ South Shore University Hospital (Formerly Southside Hospital)
- Northwell Health/ Huntington Hospital
- Northwell Health/ Syosset Hospital
- Northwell Health/ Plainview Hospital
- Northwell Health/ Long Island Jewish Medical Center
- Northwell Health/ LIJ Valley Stream Hospital
- Northwell Health/ Mather Hospital
- Long Island Community Hospital (Formerly Brookhaven Hospital)
- Mount Sinai South Nassau Community Hospital

Patient Signature: ____

Date: ______________________________