NSPC
Brain & Spine
Surgery

NEUROLOGICAL SURGERY, P.C

MOTOR VEHICLE ACCIDENT

INFORMATION FORM

PLEASE COMPLETE THIS FORM CAREFULLY AND FULLY

PATIENT INFORMATION

Name:	**Date of Birth:**
Address:	**Phone Number:**

INSURANCE INFORMATION

Insurance Company:	**Date of Accident:**
Policy Number:	**Carrier Case Number:**
Case Manager:	**Phone Number:**

MAKE SURE TO ANSWER ALL QUESTIONS

1. WHEN DID YOU INJURE YOURSELF?
2. HOW DID YOU INJURE YOURSELF? WHAT EXACTLY HAPPENED? PLEASE EXPLAIN.
3. ARE YOU CURRENTLY WORKING? ____ YES ____ NO/ IF NOT, WHEN DID YOU STOP WORKING?
4. WHAT DOES YOUR JOB DUTIES INVOLVE?
5. DID YOU HAVE ANY SPINAL PROBLEMS BEFORE YOUR INJURY? ____ YES ____ NO

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Patient Signature: _____ **Date:** _____

ADMITTING CONSENT AND FINANCIAL RESPONSIBILITY FORM

Consent for Medical Treatment. I give consent to Neurological Surgery, P. C (the "Practice), its staff, physicians and other practitioners to provide and perform such health care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for my health and well-being.

Payment of Insurance Benefits. I, and/ or my dependents, hereby authorize payment to the Practice of all monies and/ or benefits to which I and/ or my dependents may be entitled from government agencies, insurance carriers or others are financially liable for my, and/or my dependents', medical care and treatment to cover the costs of care and treatment. I also certify that I and/ or my dependent (s) authorize the Practice pursue any and all appeals or legal remedies necessary to recover payment for services rendered to me and/or my dependent (s), by the Practice, including, but not limited to, internal or external appeals of benefits denials, and litigation in any appropriate court.

ERISA Designation of Authorized Representative. I hereby designate, authorize, and convey to the Practice, to the full extent permissible under law and under any applicable insurance policy and/ or employee health care benefit plan, as my authorized representative, and I convey to the Practice: (1) the right and the ability to act on my behalf in connection in connection with any claim, fight, or cause in action that I may have under such insurance policy and/ or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/ or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed, by the provisions of ERISA. as in 29 C.F.R §2560.5031 (b)(4) with respect to any healthcare expense incurred, as a result of the services I received from the Practice and, to the extent permissible under the law to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy , including fines.

Signature on File (For Medicare patients). I certify that the information given to me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/ or The Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim I request that the payment or authorized benefits be made to me or on my behalf to the Practice for Services provided by the Practice.

Authorized for Release of Information. By signing below, I authorize the Practice to release my health information: (1) to any requesting health care provider for my further diagnosis, care of treatment or for that provider's payment or health care operation purposes; (2) to any person or entity that may be responsible for billing/ collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to the Practice or me for all or part of the Practices' charges, including but not limited to, insurers, MCO's or other benefit plans or third party payers; (4) to any government agency or other organization responsible for oversight of the Practice; (5) for the Practice's health care operations. I authorize the Practice to allow the individuals listed above to access such information through any medium including over the Internet and through the Practice's electronic medical record system.

Acknowledge of Notice of Privacy Notice. I have received a copy of the Practice' Notice of Privacy Practices, and have had the opportunity to receive assistance in the understanding and exercising these rights.

Signature. I have carefully read and fully understand this financial responsibility form and have had all my questions answered.

_____	_____	_____
Signature of Patient	**Print Name**	**Date**

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_____ _____

Signature of Patient/ Legal Representative **Relationship to Patient**

WORKERS' COMPENSATION REGISTRATION FORM

Patient Number: _____ Referring Physician: _____

Carrier Case #: _____ Referring Physician Phone #: _____

Last Name: _____ First Name: _____

Social Security #: _____

Date of birth: _____ Gender: Female Male

Street Address:

_____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Date of injury/ onset of illness: _____

On the date of injury/ illness what was the patient's job title or description of work:

_____

_____

Briefly describe how and where injury occurred:

_____

_____

Are you presently working? YES NO If no, when did you stop? _____

If yes, (check) Regular Duty? _____ Light Duty? _____

If you stopped when did you return? _____

Employer at the time of the injury: _____

Employer Address: _____

Employer Phone #: _____

Employer's Insurance Carrier: _____

Carrier Address: _____

Adjuster Name and Phone #: _____

In the in the event I fail to prosecute the claim for Workers' Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation case, I hereby agree to pay Dr. Donald S. Krieff, his usual and customary fees for services rendered to the above name claimant in the above identified case. I authorize the provider to release any information necessary to substantiate a claim.

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Signature: _____ Date: _____

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:** _____

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