Affinity Neuro Care Financial Policies

Your Visit
To expedite your visit, you should plan to arrive thirty (30) minutes before your New Patient Evaluation to speed up the registration process. We ask that you bring a current insurance card, or payment in full if you do not have insurance. Please remember that all co-pays are due at the time of services.

Payment/ Insurance policy
As a courtesy, **Affinity Neuro Care**, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.
It is the policy of **Affinity Neuro Care** that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. The office manager at your location will explain this information to you prior to your first visit. After your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.
If you are covered by health insurance for neurological services, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.
Although we are contracted with most insurance carriers, our services may not be covered by your insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.
Insurance claims are filed a maximum of twice, and then payment will be expected from the patient. To submit your claim, we must have a current copy of your insurance card on file. If you fail to make us aware of changes to your insurance carrier at the time of your visit, the responsibility for payment for the office visit and subsequent reimbursement from your new insurance carrier will be yours. All outstanding balances and co-pays will need to be paid before you can see the doctor at each office visit.
We highly recommend you also contact your insurance carrier and check into your coverage for Neurological services. Do not assume that you will not owe anything if you have more than one insurance policy.

Estimated Charges
To ensure that we accurately reflect and capture all charges provided during you visit, encounter forms are routinely reviewed for accuracy and appropriateness by trained coding staff. As a result, your charges for each visit are an estimate and are subject to change upon further review.

Cancelled Appointments
We require 24 hours' notice for cancelation of all doctors' visits. In the event of a missed appointment without prior notification, a cancellation fee of $25 will be billed to your address. In the event of a missed procedure appointment without prior authorization the fee will be $75 dollars.

Disability/FMLA
Any FMLA or disability paperwork will require 2 weeks to complete and is subject to a fee once it has been evaluated by the physician. There are no guarantees that the providers will complete this form.

Complete Insurance Information
To file your insurance, we must have complete insurance information including:

- Insured name
- Social Security Number
- Date of birth
- Group Number (if applicable)
- Subscriber/Policy Number
- Plan Address
- Plan Telephone Number

All the above information is listed on your insurance card, which will be asked for at every visit. If you are unable to provide us with an up to date insurance card, we will ask for payment in full before continuing your registration process.

Medicare Patients
If Medicare is your primary insurance, and you do not have a secondary insurance, you will be responsible for twenty percent (20%) at the time of service.

Changes in Insurance Coverage
If there is a change in insurance coverage, it is your responsibility to make sure we have all the new coverage information on file. Any medical expense not covered by your insurance will be billed to your address.

Non-Participating Insurance Plans

If Affinity Neuro Care does not participate with your insurance plan, several options are available. You may pay the balance in full today and request an itemized receipt of the visit and file it with your insurance company. The practice can file a claim to your insurance company on your behalf. If your insurance plan does not pay in full within 45 days, you will be responsible for the bill.

Primary care of Physician Referral

All patients must have a referral from a Primary Care Provider or from their referring physician before the appointment is set. If you are “self-referred,” a Medical Records Request Form will be faxed to your most recent provider.

Insurance and Billing questions

For all billing questions or claims, please contact Affinity Neuro Care’s billing department at **billing@affinityneurocare.com**.

MEDICATION REFILL POLICY

To provide excellent quality care, Affinity Neuro care adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our physician, allowing you to update our physicians on any changes in your medication regimen or advise of any new or ongoing symptoms.

- Lost, misplaced, or stolen prescriptions will not be replaced.
- Refilling of controlled substances will require an office appointment.
- Refills will only be addressed during regular office hours Monday - Thursday. Refill requests made Friday after 12 PM will not be processed until the following Monday.
- Approval of a refill may take up to 3 business days. I understand that it is my responsibility to contact the clinic in a timely manner.
- It is my responsibility to follow the medication in the dosage as prescribed. Early refill requests will not be approved.
- It is my responsibility to maintain my scheduled appointments with my provider. Repeated no shows and cancellations will result in a denial of refills.
- Early refills due to extenuating circumstances will be processed at the physician’s discretion

Medical Equipment Policy-Patient Form

Our office is equipped with examining tables that are suitable to hold the weight of an average male/female, not to exceed 300 lbs. In the event a patient’s physical weight exceeds that weight, we will make every effort to make alternative accommodations. If satisfactory alternative accommodations cannot be found and the patient wishes to proceed with medical examination on the examining table, the patient agrees that this office will not be held responsible or liable for any accident or injury the patient may sustain.

Rx Consent

By signing this consent form you are agreeing that your provider at Affinity Neuro Care may request and use your prescription medication history from other healthcare providers. This provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy. The medication history information would include medications prescribed by your health care provider at Affinity Neuro Care. as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information. I give **Affinity Neuro Care** consent to retrieve my past Rx history.

Acknowledgment to Receipt of Notice of Financial Policies and Consents

Our practice reserves the right to modify the financial policies outline above. I have reviewed this office’s Notice of Financial Policies and consents. I understand that I am entitled to receive a copy of your Notice of Financial Policies.

Patient (print): ______________________________ Date: ______________

Signature: ______________________________ Date: ______________

Relationship of Patient Representative: ______________________________

Signature: ______________________________ Date: ______________

Printed Name of Patient or Legally Authorized
(required if the patient is a minor or if the patient is unable to sign.)

New Patient Intake

Name: ____ DOB: ___________________ Phone: ______________________ Sex: M|F

Address: ____ Email: _________________________________

Pharmacy Name: ____ Pharmacy Phone: ______________________________________

PCP: ________________________________ Phone: ___________________________ Address: ____

Ref. Physician: ________________________________ Phone: ___________________________ Address: ___________________________________

May confidential messages be left on your home answering machine or voicemail? **YES: _____** **NO: ______**

Who can we contact in case of an emergency?

____

Name relationship Phone

____

Name relationship Phone

May we also release your medical information to the following people? **YES: _____** **NO: ______**

Reason for EVAL: ____ Due to Motor Vehicle Accident: Yes: __________ No: ___________

Attorney Information: ____

Disability/FMLA **Will you be needing these forms filled out?** **YES: _____** **NO: ______**
(Any FMLA or disability paperwork will require 2 weeks to complete and is subject to a fee once it has been evaluated by the physician. There are no guarantees that the providers will complete this form.)

Have you seen a neurologist within the last 5 years? **NO: ______**

__ Yes, Dr. ___________________________________ Phone: _________________________ Address: ____________________________________

Have you been to the ER for this or any other neurological problem? **NO: ______**

__ Yes, Hospital _____________________________________ Phone: _______________________ Address: ________________________________

Have you had any recent bloodwork done? Where? ____ Phone: ____________________________

Have you recently had any of the following:

Yes	**No**		**date**	**where?**	**Normal**	**Abnormal**
__	__	**MRI Brain**	________________	___________________________	______	______
__	__	**CT Scan**	________________	___________________________	______	______
__	__	**EEG** (brain wave recording)	________________	___________________________	______	______
__	__	**EMG/NCV**	________________	___________________________	______	______
__	__	**Evoked Potential Study**	________________	___________________________	______	______
__	__	**Cerebral Arteriogram**	________________	___________________________	______	______
__	__	**Carotid Doppler**	________________	___________________________	______	______
__	__	**LP** (Spinal Tab)	________________	___________________________	______	______

Name: ____

Date of birth: ____________________ **Date:** _________________

Reason for evaluation:

____

Was this caused by a motor-vehicle accident? ____ Yes ____ No

Allergies: ____

Current medications, alternatives, and vitamins: List name, dosage, and how often you take them.

____
____
____
____
____

Medical History: Please specify the date of diagnosis for each condition. If you have an illness not shown, please specify below.

- ☐ High blood pressure Date: __________________
- ☐ Diabetes Date: __________________
- ☐ High cholesterol/lipids Date: __________________
- ☐ Heart disease Date: __________________
- ☐ Thyroid disease Date: __________________
- ☐ Tumor Date: __________________
- ☐ Cancer Date: __________________
- ☐ Stroke Date: __________________
- ☐ TIA (mini stroke?) Date: __________________
- ☐ Psychiatric disease Date: __________________

Specify: ____

- ☐ Treatment by counselor Date: __________________

Other: ____

Surgical History: Please provide name and dates of operations.

- ☐ Brain __________________ Date: __________________
- ☐ Neck __________________ Date: __________________
- ☐ Back __________________ Date: __________________
- ☐ Sinus __________________ Date: __________________
- ☐ Facial __________________ Date: __________________
- ☐ Dental __________________ Date: __________________
- ☐ Vascular ________________ Date: __________________
- ☐ Heart __________________ Date: __________________
- ☐ Lung __________________ Date: __________________
- ☐ Implantations ____________ Date: __________________

Please list dates of all hospitalizations/injuries (specify):

________________________________ Date: __________
________________________________ Date: __________
________________________________ Date: __________
________________________________ Date: __________

Pregnancy history:
Are you currently Pregnant? Yes_____ No_____ N/A: _________

Neurological complaints during Pregnancy:

____

Family History:
Please list age and significant medical illnesses in maternal and paternal mother and father, sisters or brothers, and in maternal and paternal grandparents.

____
____
____
____
____
____
____
____
____
____

Social History:

1. **Do you use tobacco?** ___ No

Quit Date (if applicable): _________________
___ Yes Daily: ___ 1-9 cigs ___ 10-19 cigs ___ 20-39 cigs

2. **Any illicit drug use?** ___ No

Quit Date (if applicable): _________________
___ Yes Drugs: _______________________________________

3. **Do you drink alcohol?** ___No

Quit Date (if applicable): _________________
___ Yes Beer | Wine | Liquor *(circle)*
__2-4 Monthly __2-3 Weekly __4 or more times a week
Daily: __ 1-2 __ 3-4 __ 5-6 __ 7-9 __ 10 or more

4. **Do you drink coffee/caffeine?**

___Yes ___No ___Never
How many cups daily? _________

How many children do you have?

____

How many times a week do you exercise?

____

Who lives with you at home?

____

Marital Status?

____

Natural Support System?

____

What is your occupation?

____

Have you traveled outside of the US in the past 6 months?

____

Have you been exposed to HIV or any other STD/STI?

____

What hand do you use for writing?

____

What is the highest level of education?

____

Name: ____ DOB: _________________ Date: _________________

Review of Systems

Check the box next to the symptoms that you have noticed over the last year.

Constitutional **No complaints___**

Poor Appetite__ Weight loss__ Fever__ Chills__ Night sweats __ Weight gain__ Fatigue__ Snoring__ Always tired__ Malaise__ Apnea__ Choking__ Restful sleep__ Blackouts__ AM Headaches__ Hot flashes__ Sleepiness__ Dizziness__

Other/ Comments: ____

Eyes/Head **No complaints___**

Vision changes__ seeing spots__ Itchy eyes__ Watery eyes__ Headaches__ Double/vision__

Other/Comments: ____

Ear/Nose/Throat **No complaints___**

Hearing loss__ Ringing ears__ Ear pain__ Nasal polyps__ Nasal congestion__ Nasal drainage__ Change smell__ Nose bleed__ Sneezing__ Sinus pain__ Hoarseness__ Bad breath__ Sore throat__ Change in taste__

Other/Comments: ____

Cardiac **No complaints___**

Chest pain__ Leg swelling__ Heart skipping__ Heart murmur__ Passing out__ Heart fluttering__ Palpitations__ Waking up short of breath__ Shortness of breath while lying flat__ Other/Comments: ____

Respiratory **No complaints___**

Cough__ Pneumonia__ Phlegm__ Wheezing__ Chest tightness__ Chest injury__ Pleurisy__ Coughing blood__ Exposure to tuberculosis__ Shortness of breath at rest__ Shortness of breath with walking__

Other/Comments: ____

Gastrointestinal **No complaints___**

Indigestion__ Nausea__ Vomiting__ Bowel changes__ Constipation__ Belly pain__ Bloody stools__ Heartburn__ Tar-colored stools__ Choking on food__ Acid taste in mouth__ Diarrhea__ Pain Swallowing__

Other/Comments: ____

Musculoskeletal **No complaints___**

Arthritis__ Muscle pain__ Muscle weakness__ Joint stiffness__ Osteoporosis__ Back pain__

Other/Comments: ____

Genitourinary **No complaints___**

Bloody urine__ Frequent urination__ Burning with urination__ Incontinence__ Urination at night__ Recent Mammogram__ Recent pap smear__ Abnormal periods__ Vaginal discharge__ Decrease urine flow__

Other/Comments: ____

Skin/Breast **No complaints___**

Easy Bruising__ Nail changes__ Warts__ Acne__ Hair loss__ Hives__ Moles__ Itching__ Discoloring__ Bolls__ Rash__ Lesions__ Breast lump__ Nipple discharge__

Other/Comments: ____

Neurological **No complaints___**

Epilepsy__ Seizures ("fits) __ Paralysis__ Speech changes__ Tingling__ Numbness__ Memory problems__ Headaches__ Lack of concentration__ Poor balance__ Tremors__

Other/Comments: ____

Psychiatric: **No complaints ___**

Depression__ Difficulty concentrating__ Insomnia__ Memory loss__ Confusion__ Nervousness__ Anxiety__

Other/Comments: ____

Would you like to report any abuse at this time? YES | NO Physical | Emotional | Mental | Financial

Endocrine **No complaints___**

Excessive thirst__ Frequent urination__ Increased appetite__ Heat intolerance__ Cold intolerance__

Other/Comments: ____

Herme/Lymph **No complaints___**

Anemia__ Easy bruising__ Swollen glands__ Hemophilia__ Easy bleeding__ Sickle cell disease__

Other/Comments: ____

Allergy/Immunology **No complaints___**

Nasal drainage__ Crusting__ Seasonal allergies__ Lupus__ Allergy shots__ frequent colds__ frequent infections__ autoimmune disease__

Other/Comments: ____

Coordination of Benefits Questionnaire

Insured Name: ____
First Name Last Name MI

Insured ID #: _________________________________DOB: _______________ Relationship to Patient _____________

Patient Name: (if different from insured) ____

SECTION I

1. Do you or any member of your family have other group health insurance?
   Yes____ No_____
2. Do you or any member of your family have a Medicare Policy?
   Yes____ No_____

If you answered "No" to the above questions, the questionnaire is complete, sign, and date below.

If you answered "Yes" to either of the questions in Section I, please provide the following information (include any other health insurance coverage provided by a natural parent as established by a divorce decree, etc.). *

SECTION II

Primary Insured: ____
LAST NAME FIRST NAME MI DATE OF BIRTH

Other Insurance Company's Name:

____
Address City State Zip Code

Effective Date of Policy: __________________ Policy Id #: _____________________

List any other members covered under the above-mentioned health insurance (please include full name, date of birth, relationship, sex.

____
LAST NAME FIRST NAME MI DATE OF BIRTH

Relationship to Insured: _____________________________________ Male______ Female________

____
LAST NAME FIRST NAME MI DATE OF BIRTH

Relationship to Insured: ____ Male________ Female________

SECTION III

If you have Medicare Part A or Part B, please answer the following questions:

___ Medicare Part A Effective Date: ____________________________________

___ Medicare Part B Effective Date: ____________________________________

Signature: ____ Date: _________________________
Printed Name of Patient or Legally Authorized Representative

AUTHORIZATION TO DISCLOSE/OBTAIN PROTECTED HEALTH INFORMATION

Name: ____ DOB: _________________

I, the undersigned, authorize the release of or request access to the information specified below from the Medical record, protected patient information to Affinity Neuro Care on the above-named patient.

- Patient information is needed for: (check one)
  - ☐ Continuing Medical Care
  - ☐ Social Security/Disability
  - ☐ Insurance
  - ☐ Legal Purposes
  - ☐ School
  - ☐ Personal Use

  Other____ Dates of service: ____
- Information to be released or accessed: (check one)
  - ☐ Operative Reports
  - ☐ Lab Reports
  - ☐ All Consultation Reports
  - ☐ Imaging Reports (MRA, MRI, CT Scans, etc.)

  Other____ Dates of service: ____

- I authorize **Affinity NeuroCare**: (check one)

  ☐ **to OBTAIN confidential information from:**

____

____

____

____

____

  ☐ **to RELEASE confidential information to:**

____

____

____

____

____

- I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law.
- The information obtained or disclosed pursuant to this authorization may be subject to re-disclosure and I hold harmless **Affinity NeuroCare** and/or its representatives from liability resulting in the release or obtaining of the above protected health information.
- I understand that I may revoke this authorization in writing at any time prior to release of the protected health information specified above.
- I understand that the specified information to be released may include but not limited to history, diagnoses and or treatment of drug and alcohol abuse or use, psychiatric treatment, mental illness, communicable diseases which are protected by Federal Law 42CFR Part 2, Including HIV, AIDS, all sexually transmitted diseases.
- I understand that I may be charged a fee for copies of my medical records/protected health information according to Texas Hospital Licensing Law.

Signature: ____ Date: ___________________________

Printed Name of Patient or Legally Authorized Representative