Neuro Rehab & Pain Institute

Dr. Priti Manohar, M.D.
3125 Center Pointe Drive
Edinburg, Texas 78539
Phone (956) 683-9300 Fax (956) 683-9323

DATE: _____ PHONE: (_____) _____ CEL #:(_____) _____

PATIENT INFORMATION

NAME: _____ SOCIAL SECURITY: _____

SEX: M F AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SINGLE MARRIED SEPARATED DIVORCED MINOR WIDOW

PATIENT EMPLOYER/SCHOOL: _____ OCCUPATION: _____

EMPLOYER/SCHOOL ADDRESS: _____ PHONE: (_____) _____

IN CASE OF EMERGENCY: _____ PHONE: _____ RELATION: _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT: _____ DATE OF BIRTH: _____

RELATION TO PATIENT: _____ SOCIAL SECURITY _____ SEX: ☐ F ☐ M

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PERSON RESP. EMPLOYED BY: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ BUSINESS PHONE: (_____) _____

INSURANCE COMPANY NAME: _____ SUSCRIBER #: _____

CONTRACT #: _____ GROUP #: _____ NUMBER OF DEPENDANTS: _____

ADDITIONAL ISURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE: ☐ YES ☐ NO

PERSON RESPONSIBLE FOR ACCOUNT: _____ DATE OF BIRTH: _____

RELATION TO PATIENT: _____ SOCIAL SECURITY _____ SEX: ☐ F ☐ M

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PERSON RESP. EMPLOYED BY: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ BUSINESS PHONE: (_____) _____

INSURANCE COMPANY NAME: _____ SUSCRIBER #: _____

CONTRACT #: _____ GROUP #: _____ NUMBER OF DEPENDANTS: _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
SIGNATURE OF PATIENT, PARENT, GUARDIAN, REPRESENTATIVE DATE

_____ _____
PRINT NAME OF PATIENT, GUARDIAN, OR REPRESENTA RELATIONSHIP TO PATIENT

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AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS/*AUTORIZACION PARA EL TRATAMIENTO MEDICO DE MENORES*

Name of Minor *Nombre del Menor*	**Date of Birth** *Fecha de Nacimiento*	**Allergies/Special Conditions** *Alergias/Condicion Especial*

I/We _____ being the parent(s) or legal guardian(s) of the above named minor(s) do hereby consent to the treatment of the minor.
In my/our absence I/We do hereby appoint: Neuro Rehab and Pain Institute.

Yo/ Nosotros _____siendo el padre (padres), o guardian legal del menor denominado (menores) por la presente consiente (consentimos) al tratamiento del menor (menores) en mi/nuestra ausencia por el presente
asigno a: *Neuro Rehab and Pain Institute* .

Name *Nombre*	**Telephone Number** *Numero de Telefono*	**Relation to Patient** *Relacion al Paciente*

The above named person(s) may act on my/our behalf for any unexpected medical, dental, surgical care and hospitalization for the above named minor(s), during the period of my absence, from Neuro Rehab and Pain Institute.

El denominado tiene authorizacion de actuar para beneficio de el cuidado y hospitalizacion, medicos, dentales, y quirugicos para el menor (menores) denominado durante el periodo de mi ausencia, de:
Neuro Rehab and Pain Institute.

_____ _____
Parent /Legal Gaurdian Signature **Date**/ *Fecha*
Firma de Padre/Guardian

_____ _____
Witness Signature/ *Firma de Testigo* **Date**/ *Fecha*

Neuro Rehab & Pain Institute Financial Policy

Thank you for choosing Neuro Rehab and Pain Institute as your health care provider. We are committed to provide excellent health care services to, our patient. As part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

***It is your responsibility to provider us with your most current insurance information.**

*to better assist you and ensure prompt payment by your insurer, we will make a copy of the following: Insurance Card, Driver's License, or Photo ID, and Social Security Card

*If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.

*We must emphasize that, as medical providers, our relationship is with, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possible your employer. It is you're responsible to know and understand the level of services covered by insurance company.

*We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided in full. **You are financially responsible for services not covered by your insurance company.**

*Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our physician be listed as a provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or by our physician is not listed as a provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service and you will not be reimbursed for the charges.

*We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determined of usual and customary rates.

***Co-payments, co-insurance, and or deductibles are due at the time of service.** We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim-regardless of our estimation.

***It is your responsibility to provide us with your most current billing information.**

*Your must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.

*We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call (956) 683-9300 between 8 AM –5 PM and ask to speak to the Billing Representative.

***Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Interest on the unpaid balance at the rate of ten percent (10%) per annum will be accrued 30 days after services rendered. You will be responsible to pay all collection costs incurred, including attorney fees and court costs if applicable.

*If you are unable to pay the balance due in full, you must contact our billing department to discuss payment for past due accounts.

* If your account is assigned to a professional collection agency, you will be notified by mail that you will no longer be able to receive services from any of the Physicians at Neuro Rehab and Pain Institute.

*In the event you submit payment by check and the bank returns the check unpaid for any reasons, we will add $35.00 to your balance. In addition, we may seek additional legal remedies provided to us under Texas Law.

***If you are unable to make appointment at your schedule time, please advise us least 24 hr in advance. We will assist you with a reminder call the day before your scheduled appointment.**

***Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks, credit cards, and also offer the Care Credit Program. I have read and understand this financial policy.

_____ _____

Signature of Responsible Party **Date**

_____ _____

Patient Name **Patient Date of Birth**

Neuro Rehab & Pain Institute

Patient's Name _____ **DOB** _____
(Please Print)

Acknowledgement of Review of Notice of Privacy Practice

Reconcimeinto de Haber Revisado el Aviso Acerca de las Practicas de Privacidad.

I have reviewed this practice's Notice of Privacy Practice, which explains how my medical information will be disclosed. I understand that I am entitled to receive a copy document.
Yo he revisado el Aviso Acerca de las Practicas de Privacidad, el cual explica como se podra utilizar la informacion de salud individual identificable. Yo comprendo que tengo el derecho de recibir una copia de este documento.

_____ _____
Signature of Patient or Representative **Date**
Firma del Paciente o Representante *Fecha*

Consent for Treatment

By signing this consent, I am authorizing my physician(s) to perform and/or to order another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for diagnosis and treatment of my medical condition. This consent is valid for each visit I make to the Neuro Rehab and Pain Institute unless revoked by me orally or in writing.
Please be informed, Texas law allows a patient to be tested for possible exposure to Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissue to determine suitability for donations; 2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to the Neuro Rehab and Pain Institute infections disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested, at the expense of the Neuro Rehab and Pain Institute, if any of these situations occur during your treatment period.

_____ _____
Patient/ Legal Representative **Date**

Authorization for Release of Information

I hereby authorize the Neuro Rehab and Pain Institute to furnish information pertinent to my medical condition including but not limited to the diagnosis, treatment and care offered or rendered to me while a patient at the Neuro Rehab and Pain Institute to the following entitles: 1) to my insurer(s) , including Medicare, to which my medical bills have been assigned for payment, 2) to consultants outside the Neuro Rehab and Pain Institute to whom I may be referred for care, 3) to employees of Neuro Rehab and Pain Institute for conducting Quality Assurance and compliance activities. I understand that my medical information will not be released to any persons other than those named without my expressed written permission. **For the purpose of "Medical Information " shall mean copies of all medical records, test, x-rays, reports, and/or other materials in the possession of the Neuro Rehab and Pain Institute relating to my medical condition and purpose of actual treatment.**
I understand that by signing this consent I am also authorizing release of any information contained within the medical record, which may be related to AIDS and/or HIV antibody or antigen testing to the above mentioned persons.
By singing this Consent for Release of Medical Information, I agree not to hold Neuro Rehab and Pain Institute, their agents and employees liable for any unfavorable outcomes as the result of releasing this information. I realize that release of my medical information may be necessary before my insurer will cover that cost of my medical treatment, I may be required to pay then entire bill at the time of service.

_____ _____
Patient/ Legal Representative **Date**

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To: _____ _____
(Patient's Name) **Date**

I Dr. Priti Manohar, own ownerships or investment interests in Doctors Hospital at Renaissance, Ltd. I am referring you to Doctors Hospital at Renaissance for treatment or testing. If you object to the referral or have any questions about the notice, please let us know. This notice is given to you as required by federal law and the hospital's rules and regulations.

Receipt Acknowledged: _____
(Patient's Signature/Guardian Signature)

Para: _____ _____
(Nombre del Paciente) **Fecha**

Dra. Priti Manohar pose un interes de la propiedad o de la inversion en Doctors Hospital at Renaissance. Lo estamos refieriendo a Doctors Hospital at Renaissance para tratamiento o estudios. Si usted se opone a la remission o tiene alguna pregunta sobre el aviso, favor de dejarnos saber. Este aviso se le da a usted segun los requisitos de ley federal y las reglas y regulaciones del hospital.

_____
Firma del Paciente/Guardian

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General Policy

1. Allow 3-5 business working days to refill routine medications.
2. When you need a medication refill, please call your pharmacy and they will contact us. This reduces the possibility of errors being made when filling your prescription.
3. Urgently needed medication refills should be called to the front office and a message left for the nurse.
4. Any Rx refill messages received after 3 PM will not be called in until the next working day.
5. **PAIN MEDICATIONS** and **CONTROLLED SUBSTANCES** can only be issued during visits and must be cleared by physicians.
6. It is general policy, if it has been 4 months or more since you have been seen, you should be called to schedule an appointment.

_____ _____

Patient or Guardian's Signature Date

Thank you,
Management.

Polica General

1. Permitanos 3 a 5 dias para rellenar su medicamento de rutina.
2. Cuando necesite mas medicamento favor de hablar a su farmacia para que ellos nos hablen con la informcion.
3. Medicamento de Emergencia favor de llamar con la recepcionista y dejar un mensaje para la enfermera.
4. Mensajes para mas medicamento recivido despues de las 3:00 de la tarde no seran procesadas hasta el dia siguiente.
5. Medicamentos **PARA DOLOR** o **SUBSTANCIAS CONTROLADAS** se daran **UNICAMENTE** el dia de su cita y deberan ser autorizadas por el doctor.
6. En la polica general, si tiene 4 meses o mas de que vino a consulta, debe llamar para hacer una cita con el doctor.

_____ /Firma del Paciente o Guardian Fecha