



3355 RiverBend Drive, Suite 400, Springfield, OR 97477
(541) 686-8353

We are pleased that you have scheduled an appointment with

Please help us ensure your appointment time and reduce your waiting time by doing the following:

- ✓ Complete the enclosed forms
- ✓ Mail them in the enclosed envelope
- ✓ Confirm that your insurance plan will cover this visit.
 - ◆ Many health plans require a referral from your primary care physician.
 - ◆ Some health plans require that you see only a plan participating physician.
 - ◆ Most plans include a co-payment, payable at the time of the visit. A \$25.00 fee will be charged if co-payments is not made at the time of appointment.
 - ◆ We will bill your insurance as a courtesy. Payment amount due from patient is required with-in 30 days of receipt of insurance payment.
 - ◆ **On-the-job injuries** always require advance notification to the employer, the workers compensation insurance company, and this office, so that authorizations can be obtained.
 - ◆ **Motor vehicle accidents** are not always covered by insurance. Please see the enclosed copy of our notice to Motor Vehicle Accident Patients for important information.
 - ◆ If you do not have insurance coverage, or your insurance will not cover this visit, payment in full at the time of your visit is expected.

The day before your appointment:

- ✓ Please call (541) 686-8353 to confirm your appointment date & time
- ✓ Please HAND CARRY your new & old MRI, CAT scans & x-rays pertaining to your medical condition to your appointment. Unfortunately without these your appointment will be re-scheduled.

Please note our medication refill policy: We require 24 hours notice for medication refills. Medications will only be refilled during regular business hours, 8:00 AM through 5:00 PM Monday through Thursday. This office will not refill medications after 12:00 noon on Fridays, on weekends or on holidays.

Thank you for your help! If your physician has an emergency, your appointment time may be delayed or rescheduled.

If you need assistance, or have questions, please call us at
(541) 686-8353 or (800) 924-8353.

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Oregon Neurosurgery Specialists to use and disclose the health and medical information of _____ for the purpose of **Treatment, Payment and Health Care Operations**.
(Name of patient)

- **Treatment** (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).
- **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).
- **Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review Oregon Neurosurgery Specialists "**Notice of Privacy Practices**" for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our **Notice** by placing your initials here:_____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may change also. A summary of the **Notice** will be posted in the lobby of our office indicating the effective date of the **Notice** in the right hand corner. We will offer you a copy of the **Notice** on your first visit to us after the effective date of the then current **Notice**. We will also provide you with a copy of the **Notice** upon your request.

As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. **We are not required to agree to your request.** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I understand that I have the right to revoke this CONSENT provided that I do so In writing, except to the extent that Oregon Neurosurgery Group, has already used or disclosed the Information in reliance on this CONSENT.

(Date)

(Signature of patient) (or)

(Date)

(Signature of person authorized by law)

Financial Policy

PLEASE READ REGARDING YOUR INSURANCE

We empathize with your recent illness or accident and we appreciate you selecting us for your health care needs. We will provide you with quality care in a timely manner.

It is our policy that you pay for your services at the time of service, unless prior arrangements have been made. We will bill your insurance company(ies) as a courtesy. Please note: we will **not** forego payment while you seek legal action and/or while you wait for your policy to pay. We will bill your accident insurance first, immediately followed by billing your health care insurance company. Your accident insurance may not authorize the services, disclose your coverage nor provide us with information which will guarantee they will pay for the services you are about to receive.

We are sorry if this puts stress upon you at this time, but it will help maintain our relationship as we seek avenues to solve your health problems. We need to **keep our physician-patient relationship separate from the agreement(s) you have with your attorney and/or insurance company(ies)**. Please sign at the bottom of this form acknowledging that the services that will be rendered are fully your financial responsibility.

If you have a balance remaining after your insurance makes their payment for your service, we may agree to accept payments. However, to do this an ACH agreement will need to be signed. This is a form directing your bank to make set monthly payments as a direct deposit to this organization. There will be a \$25.00 setup fee. For more information please contact our office regarding payment arrangements.

Please be advised that we are not subject to out of state workers' compensation programs rules and regulations. Also, to abide with HB3668 Section 4 which limits motor vehicle charges to the lesser of usual and customary or to Oregon Workers Comp Fee Schedule until Personal Injury Protection (PIP) benefits are exhausted, we will apply any adjustments and all necessary write offs at the time of payment, when it is confirmed that the person is a recipient of PIP benefits.

To Oregon Neurosurgery Specialists:

I hereby state and acknowledge that I will be financially responsible for the health care services rendered to me. The bill is due and payable at the time of service, unless other arrangements have been made. I also understand that if I do have medical coverage for these services that you will bill my insurance company(ies) for me and that failure to provide you with the current and up to date information may cause you to seek payment from me directly. I give permission for the insurance company(ies) to reimburse Oregon Neurosurgery Specialists directly on my behalf. If after my insurance company(ies) has been billed and for any reason they deny coverage, I will be fully financially responsible for the payment of these services.

Patient's Signature

Patient's Name (please print)

Date

Name	Age	Height	Weight	Date
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Reason for visit _____

Prior Surgeries and Dates	Medical Illnesses or Conditions	Current Medications

Do you use tobacco Yes No
 How much _____

Do you drink alcohol Yes No
 How much _____

Drug Allergies and Reaction

Occupation _____
 Are you working? Yes No
 Date you last worked / /

Prior Occupations & Dates

Family History	Mother	Father	Siblings	Grandparents	Other
Tuberculosis	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Migraines	_____	_____	_____	_____	_____
Brain tumors	_____	_____	_____	_____	_____
Back/neck surgery	_____	_____	_____	_____	_____
other	_____	_____	_____	_____	_____

Prior Injuries and Dates

Can we leave confidential information on your home phone number? Yes No

If there is a number we can leave confidential information on please list here: _____

Additional Comments:

