Neurosurgery and Spine Northwest Patient Information

REFERRING PHYSICIAN: _____ **PRIMARY CARE PHYSICIAN:** _____

PATIENT INFORMATION: _____ Birthdate ___/___/_____ Age _____
Last Name First Name MI Month/Day/Year

Mailing Address _____
Street City State Zip

Social Security Number ___-___-____ Sex: ☐ Male ☐ Female Marital Status: _____

Race: _____ Religion: _____ Ethnicity: _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

E-mail Address: _____

Employer _____ Occupation _____

Employer Address _____ Phone ( ) _____

PREFERRED PHARMACY: _____ Address _____ Phone ( ) _____

IS THIS VISIT RELATED TO AN ACCIDENT OR INJURY? ☐ **YES** ☐ **NO**

INSURANCE INFORMATION:

Primary Insurance _____
Subscriber SSN# _____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber Employer _____
Policy Number _____
Group Number _____

Secondary Insurance _____
Subscriber SSN# _____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber Employer _____
Policy Number _____
Group Number _____

WORKER'S COMP INFORMATION:

Date of Injury _____ WC Insurance Carrier: _____

Address _____

Claim Number _____ WC Rep _____ Phone ( ) _____

EMERGENCY CONTACT (PERSON WE MAY SPEAK TO REGARDING YOUR MEDICAL CARE):

Name _____ Relationship _____

Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

May we leave a message on your answering machine at your home? . . . . . ☐ YES ☐ NO
May we leave a message at your place of employment? . . . . . ☐ YES ☐ NO
Is there anyone else whom we may speak with other than the patient or legal guardian, and the emergency contact?
☐ YES ☐ NO If yes, whom?

Name _____ Relationship _____

Name _____ Relationship _____

_____ _____ _____
Signature of patient or legal guardian Relationship to Patient Date

PLEASE CALL 208-664-5467 ONE DAY PRIOR TO YOUR APPOINTMENT TO CONFIRM. PLEASE CHECK IN 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME WITH YOUR COMPLETED PAPERWORK.

PATIENT FINANCIAL RESPONSIBILITIES

Neurosurgery and Spine Northwest (NSNW) is committed to providing the highest quality of caring, compassionate and comprehensive neurosurgical care available in the inland northwest, including your pre-treatment planning, clinical and surgical services, and the billing/payment process. It is important that you understand your financial responsibilities for the services you receive. The changing healthcare environment puts more of this responsibility in your hands. Your health insurance is a contract between you and your insurance carrier. We are providers for most major insurance companies. You are required to obtain any necessary prior authorization prior to your appointment to receive maximum coverage for our services. Your responsibilities are outlined below. Please read, initial each section, and sign below indicating your understanding and consent to our policies. Our billing office is available to assist you should you have any financial concerns regarding your care.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I assign to William F. Ganz, MD, FACS and/or NSNW all insurance payments for medical services rendered to me or to my dependents by NSNW and/or its employees. Furthermore, I authorize NSNW to furnish information to my insurance carriers concerning my illness, injuries, and/or treatments. I **understand and acknowledge that I am fully responsible for any and all amounts not covered by my insurance. All accounts are due within 90 days of service unless prior arrangements have been made.** An annual percentage rate of 18% (1.5% per month) is added to all outstanding accounts after 90 days. ***Initial:*** _____

ASSIGNMENT OF PROCEEDS: I grant and assign to NSNW any and all proceeds from any settlement or court ruling related to the condition and/or injury for which I am being treated. This amount shall not exceed the amount of unpaid services, charges, and/or expenses outstanding to NSNW. ***Initial:*** _____

FINANCIAL ARRANGEMENTS FOR SURGERY: If your treatment includes surgery, NSNW will pre-certify it with your insurance carrier, verify your insurance benefits and obtain your coinsurance and/or deductible. We will estimate your out-of-pocket cost for our surgical services and review this with you before surgery is scheduled. **A deposit for a portion of your out-of-pocket expenses is required prior to your surgery date.** ***Initial:*** _____

COLLECTIONS: If it becomes necessary for NSNW to employ a collection agency and/or attorney following default on your account, all collection fees up to an additional 35% of your outstanding balance and/or reasonable attorney fees may be added to your outstanding account balance. ***Initial:*** _____

RECORDS: I grant NSNW permission to share my medical records with my insurance carrier and other providers as needed to facilitate my treatment. ***Initial:*** _____

PRESCRIPTION REFILLS: I am aware that NSNW does **NOT** authorize new prescriptions or refills prior to 9:00am and after 4:00pm on weekdays and after 4:00pm on Friday through 9:00am on Monday. ***Initial:*** _____

PLEASANT VIEW SURGERY CENTER: I am aware that Dr. Ganz has a financial interest in Pleasant View Surgery Center and that I may choose to have surgery at Pleasant View Surgery Center, Kootenai Health or Northwest Specialty Hospital. Please notify Dr. Ganz if you have a preference. ***Initial:*** _____

In consideration for services provided by NSNW, I agree to all promises set forth above. I acknowledge my understanding and agree that I am legally responsible for my account and all costs associated with the collection of my account should I default. I agree to pay NSNW at the time of billing for all services rendered and for all costs and losses caused by my failure to pay in a timely manner. I further agree that all promises are freely given with the knowledge that I am granting NSNW substantial rights in the event I fail to pay for services in a timely manner.

_____

PLEASE PRINT Name of Patient or Responsible Party Date

_____

PLEASE SIGN Patient or Responsible Party Date