Office Policies Patient Name: _____

****Please *initial each line item below*, acknowledging you have read and understand our office policies****

_____ **NEW PATIENTS:** Bring all films or CD's related to your condition, paperwork mailed from our office, a list of medications or the bottles, a photo ID and a valid insurance card. *CD's of radiology images and an updated medication list will be required for every appointment.*

_____ **CANCELLATIONS:** must be made 24 hours prior to your appointment. *We charge $25.00 for appointments not cancelled or rescheduled 24 hours in advance.* If you are more than 15 minutes late to your appointment, you will be asked to reschedule. This fee will need to be paid prior to being seen again in our office.

_____ **MIDLEVEL PROVIDERS:** We have 2 Physician Assistant's and a Nurse Practitioner who are utilized in our office to both evaluate and treat patients. They are well trained and competent in their evaluation process, available to answer questions, and will be a part of your plan of care.

_____ **INSURANCE:** Currently, we participate with Blue Cross/Blue Shield, Medicare, Medicaid, Tricare, Workman's Compensation and Vocational Rehabilitation. *We do not file liability claims.* If you have an attorney, you will still be required to pay for your visits in full at the time of service. Although we are out of network for other insurance companies, it may be possible for you to obtain in-network or GAP authorization by contacting your insurance company and making the request due to a limited number of neurosurgeons in this area. It is your responsibility (or referring physician office) to contact your insurance company about authorization prior to your initial visit. After the initial visit, we are usually able to call if additional visits are needed. If you have questions, please do not hesitate to contact our billing department at (910)763-3333.

_____ **PAYMENT:** Co-pays are collected at check-in prior to services being rendered. If you do not have your co-pay, your appointment will be rescheduled. Payment is due from each patient at the time of service, which includes *deductibles, percentages of patient responsibility, and co-pays*. Our office will bill your insurance company for all services we provide at the office and hospital, but the hospital and other treating physicians will send a separate bill for their services. There will be a $30.00 service fee on all returned checks. Past due balances and fees for no-show appointments must be paid prior to being seen for a return appointment. If a minor is being treated, the accompanying adult will be responsible for payment. For your convenience, we accept Cash, Check, Visa, and MasterCard. Any balance due from our services is your responsibility and is due upon receipt of a statement from our office. There is also a $25.00 fee per completion of forms.

_____ **PHONE CALLS:** In the event of a question during office hours, we are available Monday through Thursday 9am–5pm and Friday 9am–3pm. If you leave a message with a staff member, every effort will be made to return your call within 24 hours. After office hours a call center will take urgent calls and page the neurosurgeon on call if needed.

_____ **PLEASE DO NOT** leave children unattended in the waiting area. All children under the age of 18 must be accompanied by a parent/guardian. If the parent is not present, the appointment will be rescheduled**.**

_____ **PATIENT APPOINTMENT WAIT TIME:** Patients are seen in order of appointment time, not time of arrival. Some patient appointments may take longer than expected because of the specialty of our practice.

_____ **ACKNOWLEDGEMENT:** I have read, understand, and agree to follow the above stated office policies.

Signature of Patient or Responsible Party: _____ Date_____

Rev 4/14