Strakowski Ultrasound

Physical Medicine Musculoskeletal and Neurodiagnostics

Patient Name_____ DOB_____ SSN# _ _ _ - _ _ - _ _ _ _
Patient Address_____
City_____ State _____ Zip _____
Email_____
Home Phone_____ Cell Phone_____ Work Phone_____
Marital Status S M D W Other:_____ Sex M F

Language_____ Race_____ Ethnicity: Hispanic/Latino Y N

Are You Employed? Yes No Disabled Retired Are You A Student? Y N
Employer Name_____ Work Phone _____

Emergency Contact_____ Relationship_____
Emergency Contact Phone Number_____ Home Cell Work

Pharmacy_____ Phone_____
Referring Doctor_____Address_____
Phone_____

If Patient Is Under 18, Which Parent or Legal Guardian Brought The Patient?

_____
Relationship Mother Father Other Address_____
DOB_____ SSN_____

Primary Insurance
Insurance Company_____
ID or Policy Number _____ Group Number _____
Name of Policyholder _____ Relationship Self Spouse Child Other
DOB of Insured_____ SS# of Insured _ _ _ - _ _ - _ _ _ _

Primary Insurance
Insurance Company_____
ID or Policy Number _____ Group Number _____
Name of Policyholder _____ Relationship Self Spouse Child Other
DOB of Insured_____ SS# of Insured _ _ _ - _ _ - _ _ _ _

I understand and request that payment of authorized insurance company benefits be made directly to Physical Medicine Musculoskeletal and Neurodiagnostics on my behalf for all rendered services. I authorize any holder of medical information about me to release information needed to determine these benefits or the benefits payable to related services. I am responsible for any co-pay, co-insurance, deductible and non-covered amounts. I authorized my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and /or mailing address provided. Yes No

Signature_____Date_____

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Consent to Treat

I, the undersigned, agree and give my consent for my physicians or their assistants to provide services deemed necessary to diagnose and treat my condition. This care may include, but is not limited to, diagnostic radiology and laboratory procedures, administration of drugs, and physical therapy.

Patient Financial Responsibility:

Fees are standardized and are based on the complexity of your visit or procedure. Payment of copayments, coinsurance, and any outstanding balance(s) is required at the time of service. We accept cash, personal checks, Visa, MasterCard and Discover. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service(s) are rendered. In order for us to file a claim, you must present a current copy of your insurance card at each visit and communicate any changes in your personal contact information.

Most insurance policies specify that some of the cost of the patient's care is the patient's responsibility. This can be accomplished through any combination of co-payments, co-insurance, or deductibles. Co-insurance and deductible are determined by your insurance company. We run these benefits ahead of scheduling your appointment and notify you at the time of scheduling. This amount is an estimate based on the services provided and your benefits at the time they were run. Once your insurance company has been billed if there is any additional payment responsibility, we will send you a statement. This charge is payable upon receipt of the statement. Once payments are received, they will be automatically applied to the oldest outstanding balance on your account. If you would like a payment to be applied to a specific charge, please notify your staff at the time of payment.

It is not the policy of Physical Medicine Musculoskeletal and Neurodiagnostics to hold your account for settlement of a legal suit. In the case of an open claim through an auto or homeowners' insurance, you are responsible for the specific charges.

Federal state laws and insurance company contracts prevent Physical Medicine Musculoskeletal and Neurodiagnostics from adjusting off co-pays, co-insurances, deductible and any other patient responsible balance after insurance has paid.

Insurance Plans

Your insurance coverage is a contract between you, your employers, and the insurance company; we are not a party to that contract. We must emphasize that as healthcare providers, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify the physician and the facility you are scheduled at participates with your plan and that the service(s) that you intend to receive are covered. In addition, because some insurance plans require either pre-certification and/or a referral from a primary care provider before you can be seen, please ask if these are required and obtain them if necessary.

Not all services are a covered benefit in all plans, so it is very important that you understand the provisions of your individual policy. Some insurance companies select certain services that they will not cover; so, we cannot guarantee payment of all claims by your insurance company. If your insurance company pays only a portion of your claim or rejects your claim, they will notify you through an explanation of benefits (EOB). Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation for your charges.

We want to confirm you are aware of the various charges you will be responsible for should you have surgery or be referred for therapy.

Charges you will be responsible for may include any co-payments, deductibles, and co-insurance due.

Making and Keeping Appointments

If you need to cancel your appointment or cannot keep your appointment, please call the office PRIOR to the appointment time. This allows us to accommodate other patients who need to be seen. No shows will result in a $35 charge that your insurance company will not pay.

Non-Payment of Outstanding Accounts

Accounts that are not paid in a reasonable amount of time may be sent to an external collections agency and reported to the credit bureaus. If this occurs, you may be required to pay the outstanding balance in full plus any application fees prior to coming back into the practice.

Returned Check Fee- Non Sufficient Funds (NSF) checks are subject to a $25 fee (in addition to fees from your bank).

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AUTHORIZATIONS

I, the undersigned agree and authorized the providers of Physical Medicine Musculoskeletal and Neurodiagnostics to provide the following:

Authorization to Provide Care:

I authorize the providers of Physical Medicine Musculoskeletal and Neurodiagnostics to provide any medical care deemed necessary according to their professional opinions.

Authorization and Release of Information for Billing

I authorize my insurance benefits to be paid directly to Physical Medicine Musculoskeletal and Neurodiagnostics. I authorize the release of any information by Physical Medicine Musculoskeletal and Neurodiagnostics to my insurance carrier, pertinent to my health insurance claim. I understand that I am financially responsible for this account unless other arrangements have been made.

Patient Certification, Authorization to Release Medical Information

I, the undersigned authorize Physical Medicine Musculoskeletal and Neurodiagnostics to release any medical information that may be necessary to request claim reimbursement from the insurance carriers or other payers to whom claims have been or are being submitted.

Credit Information and Collection Fees

I, the undersigned, agree that if payment on this patient's account is not made I will pay reasonable attorney's fees and 30% collection fees incurred for the collection process. I also authorize the release of credit information to the appropriate information gathering agencies.

I have reviewed the Physical Medicine Musculoskeletal and Neurodiagnostics Consent to Treat, Patient Financial Responsibility Policy and Authorizations: Please initial_____

I certify that I have read the forgoing and I am the patient or am duly authorized to execute the above agreement for the patient and accept its terms

Responsible Party _____Relationship to patient Self Parent/Guardian

Signature_____ Date _____

Printed Name _____

HIPAA Confidentiality & Contact Information

I understand that PMMN is legally permitted to use and disclose my protected health information ("PHI") for the purposes of treatment, payment and health care operations without my consent. You have the legal right to a copy of our current HIPAA Privacy Notice at any time that you request one.

_____ I have requested and received a copy of the HIPAA Privacy Notice today.
_____ I do not want a copy the HIPAA Privacy Notice today.

Wireless Telephone Communication

I understand that if I provide a wireless telephone number I may be contacted by text, artificial or pre-recorded messages, automatic dialing services or email for communication regarding billing and payment for services.

By my signature below, I confirm that I have read and understand the above policies and give my consent.

_____ Date _____

Signature of patient (or responsible party, if a minor)

_____

Printed name