TRIANGLE NEUROSURGERY

Registration Agreement
Financial Policy

PATIENT NAME: _____ DOB: _____ / _____ / _____

CONSENT OF TREATMENT - I, the undersigned, consent to treatment and procedures which may be performed during this and any future service, and which may include but are not limited to any medical/surgical treatment or procedures. I have the right to refuse any treatment and to be informed of the possible medical consequences of refusal. My signature on this document indicates my general consent to be treated. My physician may request that I sign a more specific form relative to any procedure that may be performed.

RELEASE OF INFORMATION - The physician(s) may disclose any or all parts of these medical records to my insurance carrier(s) and any organization(s) contractually responsible for purposes of satisfying all charges billed by the physician(s). This includes but is not limited to all claim filings, appeals, and correspondence in regard to the charges billed. The physician(s) may disclose any or all parts of these medical records to my disability insurance carrier(s) for the purposes of securing benefits payable to me.

FINANCIAL RESPONSIBILITY - Triangle Neurosurgery is required by our insurance contracts to collect all co-pays and other patient responsible amounts at the time of service. You are responsible for payment of all services rendered on your behalf. You understand that if your insurance company denies a claim, that you will be held responsible. We may ask you to contact your insurance carrier for payment status if your account remains unpaid after 45 days. Triangle Neurosurgery reserves the right to bill you directly if your insurance company is unresponsive or particularly slow in making payment. Accounts with balances will have a 1% interest charge added on every month until balance is paid. Outstanding accounts greater than 60 days may be billed to you.

If your patient account is unpaid after 30 days of receipt of your TNS statement, and/or no payment arrangements have been made with this office, your account may be subject to the following: 38% collection interest charge billed on the total amount owing, immediate reporting to a collection agency or collection attorney for non-payment of the account and your physician may no longer be able to provide care for you. If you are a post – operative patient you will no longer be provided care after your global period of 90 days. If your account is delinquent the patient and person responsible for the account will be notified of this by certified mail and given 30 days to find a new medical provider.

A $45.00 service charge will be applied to your account for all returned checks. Once a returned check has been received, all future payments must be made with cash, credit card or cashier's check.

If a disability form or FMLA is needed, there will be a fee to complete these forms. Our office requires five business days to complete all disability forms.

All past due amounts will be collected or payment plans made before disability forms are released.

Medical Records Requests – If you require a copy of your medical records you must sign a Medical Records Release of Information form and a minimum payment of $10.00 will be required.

You will be responsible for charges incurred due to failure to cancel any physician appointment within 24 hours. This failure will result in a $50.00 fee charged to your account.

You also understand and agree that the $250.00 surgery deposit is non-refundable if you should cancel a scheduled surgery date within 72 hours.

Triangle Neurosurgery has a physician assistant who will be in surgery with Dr Bullard. The fees for this service will be forwarded to your insurance company with the surgeon's fee. Please be advised that these fees may not be covered entirely by your insurance carrier, and they may become your responsibility.

THIRD PARTY LIABILITY – If the medical condition for which you are seeking treatment is the result of a liability (i.e. an auto accident or an injury caused by another) your medical insurance may refuse to pay, or may request a refund after payment is issued. Triangle Neurosurgery does not accept letters of protection and cannot pend payment until litigation is settled. Payment will be due at time of service for office care. If surgery is indicated, payment in full is required prior to scheduling surgery.

Therefore knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency or collection attorney, the undersigned shall pay all collection agency fees, court costs and attorney fees, and risk being dismissed from the physician's care at Triangle Neurosurgery.

In this agreement the words "you", "your", and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Triangle Neurosurgery.

I, the undersigned, further state that the foregoing Registration Agreement/Financial Policy has been carefully read, and that I understand the contents thereof, and have signed of my own free and voluntary act, and have not been influenced in executing this Registration Agreement/Financial Policy by any representative of Triangle Neurosurgery, PA or its agents. I hereby acknowledge the continuing nature of this agreement unless or until withdrawn in writing by me.

_____ (SEAL) _____ / _____ / _____
Patient Signature or Responsible Party Date

_____
Patient Name (Printed)

_____
Witness Signature

MEDICARE and/or MEDIGAP PATIENTS ONLY:
I request that payment of authorized Medicare and/or Medigap Benefits be made on my behalf to **Triangle Neurosurgery, PA** for any services rendered to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ (SEAL) _____ / _____ / _____
Patient Signature or Responsible Party Date

PLEASE NOTE: A signed copy of this agreement will remain in your medical record chart. You may request a signed copy for your records.

Revised 04/24/09 TNS Company/Clinic Forms/Financial Policy
Revised 01/21/10
Revised 11/12/10
Revised 01/15/11