Print

SOUTHWEST FLORIDA NEUROSURGICAL ASSOCIATES
SOUTHWEST FLORIDA REHAB & PAIN MANAGEMENT ASSOCIATES

12700 Creekside Lane, Suite 101 • Fort Myers, Florida 33919 • (239) 432-0774 • FAX (239) 432-9404
632 Del Prado Blvd. N., Suite 101• Cape Coral, Florida 33909 • (239) 772-5577 • FAX (239) 772-9961

Dear Patient:

Thank you for choosing our practice to assist in your healthcare needs. We appreciate the confidence you and your personal physician have placed in us. Please read the following instructions and information and let us know immediately if you have any questions.

FORMS: Enclosed you will find a Patient Information form along with a Pain Questionnaire. Please fill out these forms and bring them with you at the time of your appointment.

INSURANCE: Please bring your insurance cards so we can copy them for your chart. We will file your primary insurance claim for you. If your insurance requires prior authorization, please ensure it is taken care of before the day of your appointment as you cannot be seen without it and your appointment will have to be rescheduled.

PAYMENT: It is the policy of this office to advise patients that they are responsible for all bills incurred. Please be prepared to pay any copay or coinsurance amounts due at the time of service. Please note: A $10.00 processing fee will be charged for each copay not paid at time of service. Our office does not file supplemental insurances. We accept cash, check and most major credit cards.

FILMS: You are responsible to ensure that your x-rays, CT scans, MRI scans, etc., relating to your problem/injury are here for your appointment. Actual films are preferred, but disks will be accepted. If your films are being delivered to the office, please call the day before your appointment to make sure they have arrived. We regret that **your appointment will have to be rescheduled if your films are not at our office at the time of your appointment**.

MOTOR VEHICLE ACCIDENT: If you are being seen as a result of a motor vehicle accident and your insurance benefit does not pay 100% or benefits are exhausted, you will be responsible for all or part of your first appointment. If you are to have surgery, you can instruct your attorney to provide us with a Letter of Protection. A Letter of Protection simply gives permission to your attorney to pay expenses incurred at this office when a settlement has been reached on your behalf. It does not release you of your responsibility to pay any unpaid balance.

LOCATIONS: Please refer to the "Office Locations" section on the home page of our website, www.swfna.com. This will provide you with directions to the office at which your appointment has been scheduled.

If you have any questions regarding the above information and instructions, please contact our office. If you would like to learn more about our practice, please visit our website at: www.swfna.com.

Sincerely,

Southwest Florida Neurosurgical Associates
Southwest Florida Rehab & Pain Management

SOUTHWEST FLORIDA NEUROSURGICAL & REHAB ASSOCIATES

12700 Creekside Ln., Suite 101 • Fort Myers, FL 33919 • (239) 432-0774 (Neurosurgery & Rehab)
632 Del Prado Blvd. N, Suite 101 • Cape Coral, FL 33909 • (239) 772-5577 (Neurosurgery Only)
413 Del Prado Blvd. S, Suite 201 • Cape Coral, FL 33990 • (239) 772-5577 (Rehab Only)
6101 Pine Ridge Road, Desk 12 • Naples, FL 34119 • (239) 772-5577 (Neurosurgery Only)

PLEASE PRINT CLEARLY DATE _____

NAME _____ HOME PHONE _____
LAST FIRST MI

SEX: ○M ○F AGE: _____ BIRTHDATE: ____/____/____ SOCIAL SECURITY #: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ IS ADDRESS: PERMANENT ____ TEMPORARY ____

OTHER ADDRESS IF ABOVE IS TEMPORARY: _____

PATIENT'S EMPLOYER: _____ WORK PHONE: _____ YEARS EMPLOYED: _____

DRIVER'S LICENSE #: _____ STATE: _____ EMAIL: _____

INSURANCE INFORMATION (Please present your insurance card(s) for copying)

MEDICARE #: _____ MEDICARE SUPPLEMENT: _____

HEALTH INSURANCE: _____ POLICY #: _____ GROUP #: _____

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____/_____/_____ SOCIAL SECURITY #: _____

IF VISIT IS RELATED TO WORK COMP OR AN ACCIDENT, PLEASE COMPLETE BELOW

WORK COMP: EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____ DATE OF ACCIDENT: _____

ACCIDENT: AUTO ACCIDENT: _____ OTHER (STATE TYPE): _____

INSURANCE CARRIER: _____ POLICY #: _____

CLAIM #: _____ DATE OF ACCIDENT: _____ POLICY HOLDER'S NAME: _____

BIRTHDATE: _____/_____/_____ SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT: _____

ARE YOU REPRESENTED BY AN ATTORNEY? _____ ATTORNEY'S NAME: _____ PHONE #: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE BELOW

MOTHER'S NAME: _____ EMPLOYER: _____

HOME ADDRESS: _____ PHONE #: _____

MOTHER'S SOCIAL SECURITY #: _____ WORK PHONE #: _____

FATHER'S NAME: _____ EMPLOYER: _____

HOME ADDRESS: _____ PHONE #: _____

FATHER'S SOCIAL SECURITY #: _____ WORK PHONE #: _____

PLEASE COMPLETE

REFERRING DOCTOR: _____ PHONE #: _____

REASON FOR VISIT: _____

EMERGENCY CONTACT (not living with you): NAME: _____

EMERGENCY PHONE #: _____

LETTER OF PROTECTION AUTHORIZATION

I authorize my attorney, _____, to provide to Sypert Institute, P.A. a letter of protection. I understand that this will authorize my attorney to protect the medical provider's unpaid bill and pay the same from any settlement I might receive. This does not relieve me from the responsibility to provide my medical provider(s) with insurance information so the insurance can be filed. NOTE: All managed care copays must be paid at time of service.

_____

PATIENT'S SIGNATURE

MEDICARE/CHAMPUS AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical provider(s) services to the medical provider(s) furnishing the services and authorize such medical provider(s) to submit a claim to Medicare for payment.

SIGNED _____ DATE_____

PATIENT'S SIGNATURE (OR PARENT IF MINOR)

AUTHORIZATION TO RELEASE INFORMATION

I authorize any holder of medical or other information about me to release same to the insurance carrier for the purpose of payment of services.

I hereby authorize payment directly to my medical provider for all medical care benefits otherwise payable to me; this is not to be construed as an assignment of benefits unless the medical provider has a contractual agreement with the insurance company. I understand that I am responsible for any insurance deductibles and coinsurance, and I am financially responsible for my medical bills regardless of insurance coverage.

SIGNED _____ DATE_____

PATIENT'S SIGNATURE (OR PARENT IF MINOR)

PATIENT — PLEASE NOTE:

This office will prepare and file your insurance for you. If you choose to file your own, please check all data before forwarding to your insurance company. Our office will expect payment in full on the date services are rendered if you are filing your own claim. There will be a $25.00 charge for each special form you request us to complete, such as disability forms, family medical leave, etc.

I understand that if my insurance carrier controverts or rejects my claim that I/we (am/are) responsible for all charges billed by this office.

Managed Care Patients: There will be a $10.00 processing fee billed to your account each time you do not pay your required co-payment at time of service.

NOTE: You will be charged a NO SHOW FEE of $25.00 for failure to notify our office in advance of any appointment cancellation. This charge will be your responsibility as insurance does not cover this fee.

For, and in consideration of, services rendered to the above named patient, I/we jointly and severally promise to pay to the Sypert Institute, P.A. (dba as Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab & Pain Management Associates) all its charges for services rendered to and for the above named patient. I/we understand the Sypert Institute, P.A. may elect to accept or not to accept assignment of insurance benefits as it deems advisable. Any other arrangements made by me (insurance company, lawyers, etc.) does not involve the Sypert Institute, P.A. and does not change my (our) responsibility to pay for services.

All patients (excluding contracted third party payors) are assessed a 1% monthly billing fee on any balance over 120 days.

I have read and understand all of the above.

_____ _____

(PATIENT) (GUARANTOR)

Please complete this form, print it, and bring the completed form with you to your appointment.

Print

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CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Please Check One of the Following:

_____ I REQUEST THAT ALL OF MY PROTECTED HEALTH INFORMATION BE DISCLOSED ONLY TO ME AND NO OTHER FRIENDS OR FAMILY.

OR

_____ I GIVE MY PERMISSION TO THE EMPLOYEES OF SOUTHWEST FLORIDA NEUROSURGICAL ASSOCIATES AND/OR SOUTHWEST FLORIDA REHAB AND PAIN MANAGEMENT TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY MEMBERS OR FRIENDS.

NAME: _____ RELATION: _____

NAME: _____ RELATION: _____

NAME: _____ RELATION: _____

NAME: _____ RELATION: _____

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to better serve you, Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab and Pain Management would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is the policy of Southwest Florida Neurosurgical Associates and Southwest Florida Rehab and Pain Management to call you at any phone number you provide to us. Please let us know what type of message we may leave on your answering machine/voicemail by answering the following questions by circling **YES** or **NO**.

When we contact you by calling you at any telephone number you have provided us:

May we leave a detailed message on your answering machine/voicemail? ○ **YES** or ○ **NO**

If no, we will leave a message with just enough information for you to call us back.

*****Please Note: We will ALWAYS leave a detailed message on your answering machine/voicemail or with anyone who answers your telephone when we are contacting you to remind you of an appointment at our office.*****

I understand I may revoke or change this consent at anytime by filling out another consent form to replace this one.

_____ _____

Patient/Guardian/or Legal Representative Signature Date

_____ _____

Printed Name if not signed by Patient Relationship

_____

_

Internal Use Only: Please post the above information in the patient's off-bill comments.

Date Received: _____ Posted By: _____

DATE REVOKED/CHANGED_____

If revoked/changed see new consent form

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Notice of Privacy Practices

Effective April 14, 2003, all medical practices must follow certain guidelines as it pertains to the "Protected Health Information" (PHI) of their patients. PHI is defined as information about the patient, including demographic information, that may identify the patient, and relates to the patient's past, present, or future physical or mental condition and related health care services.

This short form has been created to provide you an overview explaining how we will handle your PHI and actions you can take if you feel we have not handled your PHI properly. A more detailed explanation of this Notice of Privacy Practices is available on our website at www.swfna.com.

How we handle your Protected Health Information:
We will ask each patient to sign consent from allowing Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab and Pain Management to use your PHI for three purposes only. Those purposes are for medical treatment, information required for payment of services rendered, and for conducting our operational activities. No other use of your PHI will occur without your written consent, unless it is to comply with state and federal laws.

Complaints regarding Protected Health Information:
If you feel we have improperly distributed your PHI or believe your HIPAA privacy rights have been violated by Southwest Florida Neurosurgical Associates and/or Southwest Florida Rehab and Pain Management, you may file a complaint by notifying our privacy contact listed below. Additionally, you also may file a complaint to the Secretary of Health and Human Services. We will not retaliate against any patient for filing a complaint.

If there are any questions with regard to this notice, they may be directed to our Privacy Contact, Robert O'Grady at (239) 432-0774, x5218, or at bogrady@swfna.com.

_____ _____

Patient Signature Date

_____ _____

Southwest Florida Neurosurgical Associates
Southwest Florida Rehab and Pain Management

Date