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 any copay not paid at time of service. 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 discs 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. We do not accept letters of protection from attorneys, and we do not wait for you to receive a settlement for payment of your bill. You are responsible for any coinsurance, deductibles, and copayments at the time of service.

LOCATIONS: Please refer to the enclosed map for directions to the office in 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

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DATE:_____ NAME: _____
Last First MI

HOME PHONE: _____ CELL PHONE:_____ SEX:M ☐ F ☐ AGE: _____ BIRTHDATE: ____/____/_____

EMAIL:_____ MARITAL STATUS: _____ SPOUSE'S NAME: _____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____IS ADDRESS: PERMANENT_____TEMPORARY _____

OTHER ADDRESS IF ABOVE IS TEMPORARY:_____

PATIENT'S EMPLOYER:_____ WORK PHONE: _____

PHARMACY _____ PHARMACY PHONE: _____ and/or PHARMACY CROSS STREET: _____

REFERRING PHYSICIAN: _____PHONE #:_____

PRIMARY CARE PHYSICIAN: _____PHONE #:_____

REASON FOR VISIT:_____

EMERGENCY CONTACT:
NAME:_____EMERGENCY PHONE #:_____

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

MEDICARE CARRIER:_____ POLICY#:_____GROUP#:_____

MEDICARE SUPPLEMENT:_____ POLICY#:_____GROUP#:_____

HEALTH INSURANCE: _____ POLICY#:_____GROUP#:_____

➢➢**IS REASON FOR VISIT INJURY/ACCIDENT RELATED: NO** ☐ **YES** ☐ **IF YES: WORK-RELATED** ☐ **MV**_☐_ **OTHER**_☐__

ARE YOU REPRESENTED BY AN ATTORNEY? YES ☐ NO ☐ NAME: _____PHONE: _____

WORK COMP INSURANCE:_____CLAIM#:_____DATE OF ACCIDENT:_____

EMPLOYER NAME:_____PHONE:_____

EMPLOYER ADDRESS:_____

AUTO INSURANCE:_____STATE_____POLICY#_____DATE OF ACCIDENT:_____

POLICY HOLDER'S NAME:_____ BIRTHDATE:____/_____/_____ RELATIONSHIP TO PATIENT:_____

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WE DO NOT ACCEPT LOPs (Letters of Protection from attorneys)

SIGNED_____ DATE:_____
PATIENT'S SIGNATURE (OR PARENT IF MINOR)

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 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 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 the 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 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 (coinsurance company, lawyer, 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]

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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 & Rehab Associates 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 the Sypert Institute, you may file a complaint by notifying our privacy contact listed above. 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 & Rehab Associates Date

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SYPERT INSTITUTE

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 Sypert Institute to disclose my protected health information to the following family members or friends.

Name: _____ Relation: _____Phone: _____
Name: _____ Relation: _____Phone: _____
Name: _____ Relation: _____Phone: _____

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to better serve you, Sypert Institute would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is the policy of Sypert Institute 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 that 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: _____Date Revoked/Changed: _____
Posted by: _____
Revised 06/2018