Medicare

The Cleveland Spine Institute
A Center of Excellence in Spine Health & Wellness

■ PATIENT INFORMATION (Medicare Insurance)

Last Name: _____ First Name: _____ Initial: ____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (_____) _____ - _____

Alternate Number (_____) _____ - _____

Sex: ❑ Male ❑ Female Marital Status: Single:❑ Married:❑ Divorced:❑ Other:❑

Date of Birth: _____ / _____ / _____

Social Security Number: _____ / _____ /_____

Parent's Name (if minor): _____

Emergency Contact Name and Number: (_____) _____ - _____

■ INFORMATION ABOUT YOUR PHYSCIANS

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: (_____) _____ - _____

Referring Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: (_____) _____ - _____

■ EMPLOYMENT INFORMATION

Employers Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ - _____

Your Employment Status (Please √ One):

❑ Full Time ❑ Part Time ❑ Not Employed ❑ Retired

Insurance Company Information – 'MEDICARE Patients'

Last Name: _____ **First Name**: _____ **Middle**: _____

Date of Birth: ____ / ____ / _____ Social Security #: _____ / _____ / _____

- ***MEDICARE*** **Insurance**

Medicare Number (exactly as it appears on your card): _____

Effective Date: ____ / ____ / ____ Basis for Medicare (√one): ❑ Retirement ❑ Disability

- ***SECONDARY*** **Insurance**

Insurance Company Name: _____

Address Claims Are to be Mailed To: (On Back of Your Insurance Card):

Address: _____

City: _____

State: _____ Zip: _____

Phone Number: (_____) _____ - _____

Policy Holder (Full Name if not you):

Last:_____ First:_____ Middle: _____

Birth Date: _____ /_____ / _____ S.S. #: _____ / _____ / _____

Relationship of policy holder to Patient (√ one): ❑ Self ❑ Spouse ❑ Dependent Child

Policy Number: _____

Group Number: _____

- ***THIRD PARTY*** **Insurance**

Insurance Company Name: _____

Address Claims Are to be Mailed To: (On Back of Your Insurance Card):

Address: _____

City: _____

State: _____ Zip: _____

Phone Number: (_____) _____ - _____

Policy Holder (Full Name if not you):

Last: _____ First: _____ Middle: _____

Birth Date: _____ / _____ / _____ S.S. #: _____ / _____ / _____

Relationship of policy holder to Patient (√one): ❑ Self ❑ Spouse ❑ Dependent Child

Policy Number: _____

Group Number: _____

Effective Policy Dates: Begins: _____ / _____ / _____ Ends: _____ / _____ / _____

OUR FINANCIAL / BUSINESS POLICIES

We are dedicated to providing you with the highest quality of healthcare. Beyond the practice of medicine, all healthcare providers are constantly faced with the task of working with many different insurance companies who help to coordinate your healthcare and help you meet your medical financial responsibilities. Consequently, it is important to us that you understand our Financial Policy. If you have any questions or any billing problems arise please feel free to call and discuss you concerns or questions with our billing manager at (440) 816-2227 we will work them out with you.

SELF PAY

We DO NOT accept Self Pay and we are not a Medicaid provider. In the event you do become uninsured in the course of active treatment through our offices, you do agree to assume all financial responsibilities associated with ongoing care that is provided or required. Patients who are not covered under an insurance program are required to pay all charges on the day of service. A payment arrangement can be made under certain circumstances.

PRIVATE INSURANCE

We will file a claim (bill) with your Insurance company for services rendered. All patients will be required to present a valid insurance card on the date of service. If a patient does not have a valid insurance card, then that patient will be treated as a self-pay patient. (see Self-pay Above)

CO-PAYMENTS

Co-payments must, by law, be collected at the time of service.

MANAGED CARE PLANS

Our Practice participates in most managed care plans. We will file a claim (bill) with your managed care plan if you participate in one. You are required to have a valid insurance card for these managed care plans or we must treat your office visit as self-pay (see Self-pay above).

WORKERS COMPENSATION (BWC)

It is your responsibility to notify us, at the time you register for your first office visit, that your case involves a Workers Compensation claim - otherwise we will bill your regular insurance carrier, or you will be responsible for office charges (see Self-pay above). You must have all the following information at the time of your first office visit: A valid workers compensation card and all information regarding your workers compensations claim. With the correct information we will not be able to process your claim. In the event your claim Is denied by the BWC, your regular insurance carrier will be billed. If your regular insurance carrier denies payment, then you will be held financially responsible for all charges incurred during your medical treatment.

MOTOR VEHICLE ACCIDENTS / PERSONAL INJURY

We DO NOT do any form of personal injury. We DO NOT accept letters of protection from attorneys. Therefore, you will be required to provide payment in full at the time of services or provide appropriate health insurance information that will allow us to bill for coverage of your claim(s) for office visits and/ or surgeries. In addition, you agree to ultimately accept full and complete responsibility for any and all charges that are incurred as a result of your healthcare under these circumstances. Should any guarantors (insurers, attorneys, or other agents.) fail to meet their financial responsibilities to us on your behalf, within a timely fashion, that is anything beyond the Ohio prompt payment laws, you will then become fully responsible for the full balance of unpaid charges.

ADDITIONAL INFORMATION Any account that goes beyond 90 days (3months) with an unpaid balance, for which no payment plan has been established, will be evaluated for potential collection by an outside agency. if you have any trouble meeting your financial responsibilities Please let us know and we will set up a fair payment plan for you. Finally, in agreeing to receive your healthcare through Dr. Gurley and/or In conjunction with his associates and his and/or their support staff (other physicians, nurses, physicians assistants, surgical technicians, all operating room support staff, office staff, or any other medical staff) In his and/or their treatment facilities (for example: offices, hospitals, diagnostic facilities, treatment facilities) you acknowledge, accept, and agree, and knowingly and voluntarily do so by affixing you signature below, to accept the fact that you have been duly informed that at any time during, after, or as a result of evaluation(s), recommendation(s), diagnostic procedures, and/or treatment(s) (Including all medical and surgical diagnostics and treatment modalities - for example medications, tests, operative / non-operative/ invasive/ noninvasive/ minimally invasive procedures/therapy, surgery and any other modality) that any conceivable risk(s), complication(s), and/or potential clinical outcome(s) may occur to you, or your minor, for which you are requesting consultation and treatment. If you do not understand any of the above information then you MUST speak with me first, before initiating a patient physician relationship, so I can clarify the information to a degree that you are comfortable with and can acknowledge that you can understand and accept Your signature below will indicate that you read, understand. accept and agree to the information outlined above in this Business/ Financial Poll. Otherwise, we cannot establish a physician-patient relationship and you then you have voluntarily chosen to seek your health care elsewhere assuming all responsibility/consequences/ sequelae associated with that decision.

PLEASE CAREFULLY READ AND FULLY UNDERSTAND OUR POLICIES OULINED ABOVE BEFORE SIGNING BELOW. IF YOU DON'T UNDERSTAND ANYTHING OR HAVE QUESTION ASK US FIRST, BEFORE SIGNING, AND WE WILL CLARIFY IT AND HELP YOU UNDERSTAND FIRST. OTHERWISE YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTAND, AND ACCEPT THE INFORMATION ABOVE, AS A PREREQUISET COMPONENT OF YOUR EVALUATION AND TREATMENT.

I , _____ , have read, understand, and agree to these Business and Financial Policies.

_____ _____ / _____ / _____

Signature of Patient OR Responsible Gardian Date