FILLMORE COUNTY HOSPITAL

Fillmore County Hospital is committed to providing high quality, personalized healthcare with compassion, dignity, and respect in a cost effective and safe manner - to achieve this we want you to have the opportunity to focus more on receiving treatment for your condition.

As paperwork is also important to your care, we feel that by spending time completing papers prior to your visit will provide accuracy. You can complete them at your own pace in a more private setting by doing these in your own home. This will also save you time when you present to the admission desk at the time of your visit.

Enclosed is information required to be completed prior to your visit with us. Some information is for Fillmore County Hospital and others may be for the specialty physician you are scheduled to see.

Please use the check list below as a 'reminder for your upcoming visit. If you have any questions, please call us at 402-759-4924 or 1-800-277-0706.

If instructions are included for your procedure, please read and follow them accordingly. If you have any questions, please do not hesitate to call. These are yours to keep.

To avoid duplicate work on your part, please fill out the forms in their entirety and bring them to your scheduled visit.

Patient Information Data _Medicare Questionnaire _Specialty Physician Questionnaire

☐ Bring insurance card(s). It is your responsibility to contact your insurance company for pre-certification or pre-authorization prior to having procedures/tests that request them. If your pre-certification or pre authorization is not done prior to your procedurere/test, your insurance company will penalize you and will not pay their portion of the bill. You will then be responsible for payment.

If you are under the age of 19, a parent/guardian must be present to sign the consent the day of visit or your Parent/ guardian may make arrangements to have the consent signed prior to the visit by contacting the Admission Office.

If no information is given in the scheduled appointment box to the right, someone from Fillmore County Hospital or your specialty physician office will be contacting you.

Sincerely,

The Specialty Clinic Team
Fillmore County Hospital

_____
Name
Your scheduled appointment is:
_____
Day Date Time
_____
Scheduled Physician or Procedure
We will contact you if this changes.

FILLMORE COUNTY HOSPITAL
(402) 759-3167. 1900 F STREET. GENEVA. NE 68361. *www.myfch.org*

PATIENT REGISTRATION
NEUROLOGY ASSOCIATES, P.C.

DATE_____

Patient's Name(Last)_____(First)_____(M.I.)_____

Responsible Party if Under Age 18:_____Race_____Ethnicity_____

SSN:_____ Sex: Male____Female____ Birth Date:_____

Marital Status: Single_____Married_____Divorced_____Widowed_____Separated_____

Street/Billing Address:_____

City:_____State:_____Zip:_____-_____

Home Phone:_____Cell Phone:_____Work Phone:_____

____Yes____No Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

Occupation:_____Employer's Name:_____

Referring Physician:_____Primary Care Physician:_____

What is the reason for your evaluation today?_____

What is your preferred pharmacy?_____

Preferred Spoken Language_____

PRIMARY CONTACT PERSON (SPOUSE, PARENT, SIGNIFICANT OTHER, ETC.)

Name:_____Relationship:_____DOB:_____

Address:_____Employer:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

____Yes____No I give the physicians/staff of NAPC permission to discuss my medical information with this individual.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Neurology Associates, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation fees, and court costs. I hereby authorize Neurology Associates, P.C. and its employees and agents TO RELEASE ALL INFORMATION, reports, and records if necessary for the purposes of treatment, payment and healthcare operations, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors. If I have a liability injury, I understand that I have the option of using my health insurance, if available, or I will be expected to pay for treatment.

I acknowledge that I have been offered a copy of Neurology Associates, P.C. Notice of Privacy Practice Policy, which describes how my health insurance information may be used or disclosed.

Signature:_____Date:_____

Responsible Person if Patient is a Minor:_____Date:_____

INSURANCE INFORMATION

MEDICARE

Is Medicare Primary?_____Yes_____No Medicare #_____
Railroad Medicare Number_____
Medicare Advantage Plan (Unicare, Secure Horizons, etc.) Name_____
Plan Number_____

1) Are you a Veteran?____Yes____No
   If yes, were you referred to us by the VA?____Yes____No
   If yes, do you have a written referral for today?____Yes____No
2) Do you have a Federal Black Lung Card?____Yes____No
3) Do you have a Veterans FEE BASIS ID Card?____Yes____No
4) Are you covered by a current employer's health insurance plan through you or your spouse's employer? ____Yes____No
5) Are you entitled to Medicare because of disability or End Stage Renal Disease?____Yes____No

MEDICAID COVERAGE

Are you covered by Medicaid?_____Yes_____No Medicaid Plan Number_____
Coventry Cares _____ UHC Community Plan_____
Arbor Health Plan_____ General Assistance_____
Case Worker's Name_____ Case Worker's Phone_____

OTHER INSURANCE COVERAGE

1) Insurance Company Name:_____ Primary?_____Yes_____No
Subscriber's Name_____ Relationship to Patient_____
Policy #:_____ Group #:_____ Employer:_____
Subscriber's SSN:_____ Subscriber's DOB:_____

2) Insurance Company Name:_____ Secondary?_____Yes_____No
Subscriber's Name:_____ Relationship to Patient_____
Policy #:_____ Group#:_____ Employer:_____
Subscriber's SSN:_____ Subscriber's DOB:_____

*****Please provide us with your medical insurance card(s) for photocopying*****

WORKERS COMPENSATION CLAIMS

Employer_____ Contact Person_____
Employer Address_____ Phone_____
Work Comp Company_____ Adjuster_____
Address_____
Phone_____ Claim Number_____ Injury Date_____
Have you retained an attorney regarding this accident?____Yes____No (If yes, Attorney Name and Address)_____

SIGNATURE_____ DATE_____

FINANCIAL POLICY
FOR NEUROLOGY ASSOCIATES, P.C.

The following describes the financial policy of our office. Please read this policy carefully. If you have any questions regarding this, please ask the receptionist or contact our office.

1) **MEDICARE** – We participate with Medicare and will file your claim and any supplement/secondary insurance for you. You will receive a balance due bill after all insurance has processed your claim. You are responsible for any balance your insurance does not cover.

2) **INSURANCE COMPANIES WE PARTICIPATE WITH** – We participate with Medicare, Humana Medicare (but not HMO Humana Medicare), Blue Cross/Blue Shield of Nebraska, Private HealthCare Systems, Midlands Choice, Coventry, One Health Plan, Choicecare, United Healthcare, and Mailhandlers (Coventry/First Health only). We will collect any copay that is due at the time of service, and will file your claim for you. You will be billed for any balance due (including deductible, copays/coinsurance) once insurance has processed your claim.

3) **INSURANCE COMPANIES WE DO NOT PARTICIPATE WITH** – We will file your claim for you You are responsible for any balance they do not cover including deductible, copays and coinsurance. If after a reasonable amount of time your insurance has not paid your claim, we will look to you for payment in full.

4) **MEDICAID** – We are Nebraska Medicaid providers including the managed care plans; Coventry Cares, Arbor Health Plan and United HealthCare Community Plan. We will file your claim for you. You must present a copy of your current Nebraska Medicaid card as well as any managed care Medicaid card, and any copay at the time of service. If you have private health insurance or Medicare in addition to Medicaid, you will need to provide us with that information also. We are NOT providers for any out of state Medicaid Plans. If you have an out of state Medicaid plan, you will need to contact our office before your appointment.

5) **WORKERS COMPENSATION** – We will file your claim to your employer/ workers compensation insurance carrier. You will need to provide us with this information at the time of service. In the event that workers compensation is denying your claims, we will file your claim with your health insurance, and look to you for payment of any balance. You will need to provide us with your health insurance information at the time of service. If you have retained legal representation for your workers compensation case, we ask that you provide us with their name and address. Please be aware that we cannot be expected to wait for the conclusion of a lengthy settlement before being paid. We will still require you to give us your health insurance information when you have a workers compensation claim.

6) **LIABILITY/MOTOR VEHICLE ACCIDENT** – In the case of motor vehicle accidents or legal cases where another party is presumed liable for your expense, we look to you (the party receiving service) for payment and cannot be expected to wait for the conclusion of a lengthy settlement before being paid. <u>You are expected to settle your account as above.</u> We do not bill attorneys or wait for settlements. You will need to use your health insurance if available or you will be considered self-pay. If using your health insurance you will be responsible for payment of all copays, deductible and coinsurance amounts. We will provide your attorney/liability insurance carrier with a copy of your bill upon request.

7) **SELF PAY** - If you do not have health insurance, payment in full is expected at the time of service. You will be required to pay a predetermined amount prior to seeing the doctor based on the expected type of service, such as consultation and testing (EMG and nerve conductions) as indicated to us by your referring physician. If services exceed this predetermined amount, you will be balance billed. If any collected amount exceeds services rendered, this will be promptly refunded. We do accept Visa, Mastercard and Discover Card. (Please contact our billing department for the predetermined charge amounts.)

8) **NONPAYMENT/TERMINATION** - Non-payment on any account will result in collection action, and/or possible termination of the patient/physician relationship. All accounts are reviewed on a monthly basis and information obtained or action taken is noted accordingly. Termination of the patient/physician relationship will be made in writing with a 30-day notice of emergency-only treatment. No appointments will be scheduled after official termination has been made.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY FOR PAYMENT OF PROFESSIONAL FEES. MY SIGNATURE REPRESENTS KNOWLEDGE AND UNDERSTANDING OF THE ABOVE POLICY.

____Yes____No Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine/voice mail?

Patient or Guarantor Signature:_____Date:_____

Print Patient Name:_____Date of Birth:_____