# Neuro Rehab & Pain Institute

**Dr. Priti Manohar, M.D.**
**3125 Center Pointe Drive**
**Edinburg, Texas 78539**
**Phone (956) 683-9300 Fax (956) 394-1229**

**DATE: _____ PHONE: (_____) _____ EMAIL : _____**

## PATIENT INFORMATION

**NAME: _____ SOCIAL SECURITY: _____**

**SEX: □ M □ F AGE: _____ DATE OF BIRTH: _____**

**ADDRESS: _____CITY: _____STATE: _____ZIP CODE: _____**

**□SINGLE □MARRIED □SEPARATED □DIVORCED □MINOR □WIDOW**

**PATIENT EMPLOYER/SCHOOL: _____OCCUPATION: _____**

**EMPLOYER/SCHOOL ADDRESS: _____ PHONE: (_____) _____**

**IN CASE OF EMERGENCY:_____PHONE:_____RELATION: _____**

## PRIMARY INSURANCE

**PERSON RESPONSIBLE FOR ACCOUNT: _____ DATE OF BIRTH: _____**

**RELATION TO PATIENT: _____SOCIAL SECURITY_____ SEX: □ F □ M**

**ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____**

**PERSON RESP. EMPLOYED BY: _____ OCCUPATION: _____**

**BUSINESS ADDRESS: _____ BUSINESS PHONE: (_____) _____**

**INSURANCE COMPANY NAME: _____SUSCRIBER #: _____**

**CONTRACT #: _____ GROUP #: _____ NUMBER OF DEPENDANTS: _____**

## ADDITIONAL ISURANCE

**IS THE PATIENT COVERED BY ADDITIONAL INSURANCE: □ YES □ NO**

**PERSON RESPONSIBLE FOR ACCOUNT: _____ DATE OF BIRTH: _____**

**RELATION TO PATIENT: _____SOCIAL SECURITY_____ SEX: □ F □ M**

**ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____**

**PERSON RESP. EMPLOYED BY: _____ OCCUPATION: _____**

**BUSINESS ADDRESS: _____ BUSINESS PHONE: (_____) _____**

**INSURANCE COMPANY NAME: _____SUSCRIBER #: _____**

**CONTRACT #: _____ GROUP #: _____ NUMBER OF DEPENDANTS: _____**

**I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**
**The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.**

_____ _____
**SIGNATURE OF PATIENT, PARENT, GUARDIAN, REPRESENTATIVE** **DATE**

_____ _____
**PRINT NAME OF PATIENT, GUARDIAN, OR REPRESENTA** **RELATIONSHIP TO PATIENT**

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# NEURO REHAB AND PAIN INSTITUTE
# FINANCIAL POLICY

Thank you for choosing the Neuro rehab and Pain Institute as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

**All patients must read and sign this form prior to receiving services.**

***It is your responsibility to provide us with your most current insurance information.**

* To better assist you and ensure prompt payment by your insurer, we will make a copy of the following: Insurance card, Driver's License or Photo ID, and Social Security Card
* If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
*We must emphasize that, as medical providers, our relationship is with, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possible your employer. It is your responsibility to know and understand the level of services covered by insurance company.
* We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided in full. **You are financially responsible for services not covered by your insurance company.**
* Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our physician is listed as a provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as a provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service and you will not be reimbursed for the charges.
*We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determined of usual and customary rates.
*Co-payments, coinsurance and or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from you insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

***It is your responsibility to provide us with your most current billing information.**

*You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
*We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30- days after receipt of the initial statement. You can call (956) 683-9300 between 9 AM- 5 PM and ask to speak to the Billing Representative.
***Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Interest on the unpaid balance at the rate of ten percent (10%) per annum will be accrued 30 days after services rendered. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
*If you are not able to pay the balance due in full, you must contact our billing office to discuss payment for past due accounts.
*If your account is assigned to a professional collection agency, you will be notified by mail that you will no longer be able to receive services from any of the physicians at Neuro rehab and Pain Institute.
*In the event you submit payment by check and the bank returns the check unpaid for any reasons, we will add $35.00 to your balance. In addition, we may seek additional legal remedies provided to us under Texas law.
*If you are unable to make appointment at your schedule time, please advise us at least 24 hours in advance. We will assist you with a reminder call, on the day before your scheduled appointment. Please be aware that this is just a courtesy call and is not an obligation. **While we understand that unforeseen circumstances may require you to miss an appointment or postpone at the last minute, we reserve the right to charge for missed appointments or appointment cancelled with less than 24 hours' notice. Which would be $50.00 for an office visit and a $200.00 charge for a procedure. We will refuse to schedule an appointment for any patient after three such incidents and you will be discharged from the physician's serves.**
***Failure to keep your account balance current may require us to cancel or reschedule your appointment.**
***You will be charged a $10.00 fee for rewriting prescriptions issued by Texas Department of Public Safety within 1 month of the date of initial prescription.**

Full payment is due at the time of service. We accept cash, checks, credit cards, and also offer the Care Credit Program. I have read and understand this Financial Policy.

_____ _____
Signature of Responsible Party Date

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**TITLE:** HIPAA - Photographing, Video Recording, Audio Recording, and Other Imaging of Patients, Visitors

**Effective Date:** June 16, 2017

**Status:** Final

**Replaced:** New Policy

**Purpose:**

1. To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and any and all other Federal Regulations and interpretive guidelines.
2. To establish guidelines for situations where patients and/or workforce members may or may not be photographed, video or audio recorded or otherwise imaged within Neuro Rehab & Pain Institute (NRPI).

**Definitions:**

1. Audio Recording: recording an individual's voice using video recording (e.g., video cameras, cellular telephones), tape recorders, or other technologies capable of capturing audio.
2. Authorization: a written form executed by the patient or the patient's legal representative that meets the requirements in the Authorization for Uses and Disclosures of Protected Health Information policy.
3. Consent: the patient's or patient's legal representative's written acknowledgment and/or agreement of the use and/or disclosure of protected health information for treatment, payment, or health operations purposes or other reasons permitted by the HIPAA Privacy Rule.
4. Photography: recording an individual's likeness (e.g., image, picture) using photography (e.g., cameras, cellular telephones), video recording (e.g., video cameras, cellular telephones), digital imaging (e.g., digital cameras, web cameras), or other technologies capable of capturing an image (e.g., Skype).

**Thank you, Neuro Rehab & Pain Institute**

_____ _____

**Patient/ Legal Representative** **Date**

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Name of Patient: _____ DOB _____

Authorization to disclose health information directly to Patient Electronically.

I understand that any medical records may contain reports, test results and notes that only physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent any misunderstanding of the information contained in these entries. I will not hold Neuro Rehab and Pain Institute liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of patient or legal representative Date

_____

Relationship to Patient (If Legal Representative

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## VII. ACKNOWLEDGEMENT AND REQUEST RESTRICITIONS.

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient DOB: _____

SIGNATURES: _____

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to patient: _____

Witness (optional) _____ Date: _____

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Patient's Name _____ DOB _____

By signing this consent, I am authorizing my physician(s) to perform and/or to order another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for diagnosis and treatment of my medical condition. This consent is valid for each visit I make to the Neuro Rehab and pain Institute unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissue to determine suitability for donations; 2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to the Neuro Rehab and Pain Institute infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested, at the expense of the Neuro Rehab and Pain Institute, if any of these situations occur during your treatment period.

_____ _____
**Date** **Patient/Legal Representative**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize the Neuro Rehab and Pain Institute to furnish information pertinent to my medical condition including but not limited to the diagnosis, treatment and care offered or rendered to me while a patient at the Nero Rehab and Pain Institute to the following entities: (1) to my insurer(s), including Medicare, to which my medical bills have been assigned for payment, (2) to consultants outside the Neuro Rehab and Pain Institute to whom I may be referred for care, (3) to employees of Nero Rehab and Pain Institute for conducting Quality Assurance and compliance activities. I understand that my records may be released to state and federal courts on issuance of a subpoena without my permission. I understand that my medical information will not be released to any persons other than those named without my expressed written permission.
For the purpose of this release, "medical information" shall mean copies of all medical records, test, x-rays, reports and/or other materials in the possession of the Nero Rehab and Pain Institute relating to my medical condition and proposed or actual treatment. **I understand that by signing this consent I am also authorizing release of any information contained within the medical record which may be related to AIDS and/or HIV antibody or antigen testing to the above-mentioned persons.**

By signing this Consent for Release medical Information, I agree not to hold Neuro Rehab and Pain Institute, their agents and employees liable for any unfavorable outcomes as the result of releasing this information. **I realize that release of my medical information may be necessary before my insurer will cover that cost of my medical treatment, I may be required to pay the entire bill at the time of service.**

_____ _____
**Date** **Patient/Legal Representative**

Patient's Name_____ Date of Birth_____
**(Please print)**

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## POLICY FOR DIVORCED OR SEPARATED PARENTS

Neuro Rehab & Pain Institute is dedicated to our patients and providing quality medical care to your child (ren). Children of divorced/separated parents sometime present our practice with unique challenges; therefore, the following policy has been established to avoid misunderstanding going forward.

**PLEASE READ & AGREE TO THE FOLLOWING SO THAT WE MAY PROVIDE CARE TO YOUR CHILD (REN)**

1. The provider & office staff will not be put in the middle of domestic issues or disagreements over the phone or in the office
2. Please make decisions regarding appointments and/or any office procedure prior to visiting our practice
3. "Joint Custody" means that each parents has equal access to the child medical records, without a court order we will not stop either parent from looking at their child's chart or obtaining any results, if there is a dispute between the parents regarding custody and custody agreements has been reached, we will need to see documentation specifying the legal guardian.
4. Only in situation where there is confirmed documented court order with one of the parents be denied access to the child's health record or visit at the office, Neuro Rehab & Pain Institute must have a copy of child's file.
5. If there's NOT a court order on file, either parent can sign a consent to treat form that authorizes and named individual to bring your child to our practice, be present during the visits and consent for treatment, We will not be involved in any disputes regarding named individuals on the consent form unless instructed by the court, either parent can schedule an appointment for their child, be present for the visit/procedure, and obtain a copy of medical records.
6. It is both parents' responsibility to communicate with each other about patient's care, it is NOT the provider responsibility to communicate visit information to each parent separately, Provider WILL NOT call the non-attending parent following visits, and we will not call a parent to notify of an appointment scheduled by the other.
7. The responsibility of the bill for minors is with the Parent or legal guardian, it is our policy to collect payment at the time of service from the parent, guardian who brings the child in for appointment.
8. The parent or guardian who completes the information sheet and signs the assignment and release WILL BE THE GUARANTOR regardless of insurance coverage.
9. We reserve the right to charge an administrative fee for copying records should the request become excessive
10. Should the issues that come between parents become disruptive to our organization or there is noncompliance with this policy, we reserved the right to discharge the family from the practice.

**BY signing this form, you agree to honor the above policy and understand the breaking this agreement may result in the discharge of your family from the practice.**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Signature of Parent/Guardian | Relationship to Patient | Date |
| _____ | _____ | _____ |
| Signature of Parent/Guardian | Relationship to Patient | Date |

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# AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

| NAME OF MINOR | DATE OF BIRTH | ALLERGIES/SPECIAL CONDITIONS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

I/WE _____ BEING THE PARENT (S) OR LEGAL GUARDIAN (S) OF THE ABOVE-NAMED MINOR (S) DO HEREBY CONSENT TO THE TREATMENT OF THE MINOR.
IN MY/OUR ABSENCE I/WE DO HEREBY APPOINT: _____

| NAME | TELEPHONE NUM | ADDRESS |
|---|---|---|
| | | |
| | | |
| | | |

THE ABOVE-NAMED PERSON (S) MAY ACT ON MY/OUR BEHALF FOR ANY UNEXPECTED MEDICAL, DENTAL, SURGICAL CARE AND HOSPITALIZATION FOR THE ABOVE-NAMED MINOR (S), DURING THE PERIOD OF MY ABSENCE, FROM: _____.

_____ _____
PARENT/LEGAL GUARDIAN SIGNATURE DATE

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General Policy

1. Allow 3-5 business working days to refill routine medications.
2. When you need a medication refill, please call your pharmacy and they will contact us. This reduces the possibility of errors being made when filling your prescription.
3. Urgently needed medication refills should be called to the front office and a message left for the nurse.
4. Any Rx refill messages received after 3 PM will not be called in until the next working day.
5. **CONTROLLED SUBSTANCES** can only be issued during visits and must be cleared by physicians.
6. It is general policy, if it has been 4 months or more since you have been seen, you should be called to schedule an appointment.

_____ _____

Patient or Guardian's Signature Date

Thank you,
Management.

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# TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting **NEURO REHAB & PAIN INSTITUTE** at **956-683-9300**.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____
Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____
Witness Signature Date