

# Neuro Rehab & Pain Institute

Dr. Priti Manohar, M.D.

3125 Center Pointe Drive

Edinburg, Texas 78539

Phone (956) 683-9300

Fax (956) 683-9323

DATE: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_ CEL #:(\_\_\_\_) \_\_\_\_\_

## PATIENT INFORMATION

NAME: _____	SOCIAL SECURITY: _____				
SEX: M F AGE: _____	DATE OF BIRTH: _____				
ADDRESS: _____	CITY: _____ STATE: _____ ZIP CODE: _____				
<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> SEPARATED	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> MINOR	<input type="checkbox"/> 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: <input type="checkbox"/> F <input type="checkbox"/> 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 INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO	
PERSON RESPONSIBLE FOR ACCOUNT: _____	DATE OF BIRTH: _____
RELATION TO PATIENT: _____	SOCIAL SECURITY _____ SEX: <input type="checkbox"/> F <input type="checkbox"/> 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 REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

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## **AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS/AUTORIZACION PARA EL TRATAMIENTO MEDICO DE MENORES**

<b>Name of Minor</b> <i>Nombre del Menor</i>	<b>Date of Birth</b> <i>Fecha de Nacimiento</i>	<b>Allergies/Special Conditions</b> <i>Alergias/Condicion Especial</i>

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: Neuro Rehab and Pain Institute.

*Yo/ Nosotros \_\_\_\_\_ siendo el padre (padres), o guardian legal del menor denominado (menores) por la presente consiente (consentimos) al tratamiento del menor (menores) en mi/nuestra ausencia por el presente asigno a: Neuro Rehab and Pain Institute.*

<b>Name</b> <i>Nombre</i>	<b>Telephone Number</b> <i>Numero de Telefono</i>	<b>Relation to Patient</b> <i>Relacion al Paciente</i>

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 Neuro Rehab and Pain Institute.

*El denominado tiene autorizacion de actuar para beneficio de el cuidado y hospitalizacion, medicos, dentales, y quirurgicos para el menor (menores) denominado durante el periodo de mi ausencia, de: Neuro Rehab and Pain Institute.*

\_\_\_\_\_  
**Parent /Legal Gaurdian Signature**  
*Firma de Padre/Guardian*

\_\_\_\_\_  
**Date/ Fecha**

\_\_\_\_\_  
**Witness Signature/ Firma de Testigo**

\_\_\_\_\_  
**Date/ Fecha**

# Neuro Rehab & Pain Institute Financial Policy

Thank you for choosing Neuro Rehab and Pain Institute as your health care provider. We are committed to provide excellent health care services to, our patient. As 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 you're responsible 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 be 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 by 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, co-insurance, and or deductibles are due at the time of service.** We will estimate the amount you owe based on information we receive from your 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 8 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 fees and court costs if applicable.

\*If you are unable to pay the balance due in full, you must contact our billing department 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 least 24 hr in advance. We will assist you with a reminder call the day before your scheduled appointment.**

**\*Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

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

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Date of Birth



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To: \_\_\_\_\_  
(Patient's Name) Date

**I Dr. Priti Manohar, own ownerships or investment interests in Doctors Hospital at Renaissance, Ltd. I am referring you to Doctors Hospital at Renaissance for treatment or testing. If you object to the referral or have any questions about the notice, please let us know. This notice is given to you as required by federal law and the hospital's rules and regulations.**

Receipt Acknowledged: \_\_\_\_\_  
(Patient's Signature/Guardian Signature)

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Para: \_\_\_\_\_  
(Nombre del Paciente) Fecha

**Dra. Priti Manohar pose un interes de la propiedad o de la inversion en Doctors Hospital at Renaissance. Lo estamos refieriendo a Doctors Hospital at Renaissance para tratamiento o estudios. Si usted se opone a la remision o tiene alguna pregunta sobre el aviso, favor de dejarnos saber. Este aviso se le da a usted segun los requisitos de ley federal y las reglas y regulaciones del hospital.**

\_\_\_\_\_  
Firma del Paciente/Guardian

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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. **PAIN MEDICATIONS** and **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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## Polica General

1. Permitanos 3 a 5 dias para rellenar su medicamento de rutina.
2. Cuando necesite mas medicamento favor de hablar a su farmacia para que ellos nos hablen con la informcion.
3. Medicamento de Emergencia favor de llamar con la recepcionista y dejar un mensaje para la enfermera.
4. Mensajes para mas medicamento recibido despues de las 3:00 de la tarde no seran procesadas hasta el dia siguiente.
5. Medicamentos **PARA DOLOR** o **SUBSTANCIAS CONTROLADAS** se daran **UNICAMENTE** el dia de su cita y deberan ser autorizadas por el doctor.
6. En la polica general, si tiene 4 meses o mas de que vino a consulta, debe llamar para hacer una cita con el doctor.

\_\_\_\_\_  
/Firma del Paciente o Guardian

\_\_\_\_\_  
Fecha