Southwest NeuroSpine Institute
www.swnsi.com
(915) 590-2225

Patient Registration Form

Please PRINT and COMPLETE ALL sections below!

Patient Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name: (Last)_____ (First)_____(Middle)_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other _____

Social Security Number: _____-_____-_____ ☐ Female ☐ Male Date of Birth:_____/_____/_____

Race:☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hawaiian/Pacific Islander ☐ White ☐ Other

Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

Address:_____

City, State, Zip Code:_____

E-mail Address:_____

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Self-Employed ☐ Unemployed ☐ Disabled

Occupation (even if not working):_____ Employer:_____

Emergency Contact Name_____ **Phone Number**:(____)_____-_____

Emergency Contact Relation to Patient_____

Primary Care Physician _____ Referring Physician:_____

How did you hear about Dr. Martin? _____

Policy Holder Information (If other than patient) This is the person who holds the insurance policy

Name: (Last)_____ (First)_____ (Middle)_____

Social Security Number: _____-_____-_____ ☐ Female ☐ Male Date of Birth:_____/_____/_____

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

Address:_____

City, State, Zip Code:_____

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer:_____ Occupation:_____

Patient Relationship to Responsible Party:_____

Pharmacy Information (in case prescriptions need to be sent –no mail order or military facilities)

Pharmacy Name:_____ _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone:(____)_____-_____ Fax :(____)_____-_____

_____

Assignment of Benefits/Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Southwest NeuroSpine Institute P.A., Southwest Neurosurgical Consultants LLC, George Martin, M.D., and any assisting practitioners for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____/_____/_____ Signature:_____

Southwest NeuroSpine Institute

Do we have permission to:

Send medical results to your home Y_____ N _____

Communicate with you via e-mail Y _____ N _____

Do we have permission to leave messages on your voicemail?

	YES	NO
HOME		
WORK		
CELL		

I give permission to share appointment information with the person(s) listed below:

Name (relationship): _____

Name (relationship): _____

I give permission to share medical information with the person(s) listed below:

Name (relationship): _____

Name (relationship): _____

I give permission to share billing information with person(s) listed below:

Name (relationship): _____

Name (relationship):_____

I also acknowledge that I have received a copy of the Privacy Practices Notice from the office of Southwest NeuroSpine Institute, PA.

Name of Patient (print): _____

Signature of Patient: _____ Date: _____

Southwest NeuroSpine Institute Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you with the finest health care available. All patients must complete and sign all check-in forms before seeing the doctor. You are required to bring your insurance card(s) and picture ID to every visit. Be sure to inform the receptionist of any changes in address, phone numbers, or insurance coverage.

Office Visits: Payment in full for all office visits is expected on the day of your appointment unless you have insurance that will be filed for your visit. Copays, deductibles, and co-insurance amounts will be collected before you are seen by the physician. We accept cash, check, or credit cards (VISA, MasterCard, and Discover). **Failure to pay your copay or co-insurance will result in your appointment being rescheduled.**

Authorization for office visits: If your insurance requires authorization to see a specialist, it is your responsibility to make sure this is received in our office prior to your appointment. **Your visit will be rescheduled if there is no authorization on file.** If you are seen without an authorization, you are financially liable for the office visit charge.

Workers Compensation Cases: If you are visiting as a patient under Workers Compensation, we must have a documented referral at the time of your visit and have your adjuster call and give information about your case prior to your appointment. **Failure to provide this information will result in your visit being rescheduled.**

Third Party Payors: If you are being represented by an attorney as a result of an accident or injury and are expecting reimbursement from a third party, you are still responsible for your bill at the time services are rendered. No arrangements will be made based on prospective third party payments.

Self-Pay: If you are a non-insured patient, you will be required to pay the full amount before being seen by the physician. **Your appointment will be rescheduled if you are unable to pay for your visit at the time of service.**

Missed Appointments – **Unless you have cancelled at least 24 hours in advance, our policy is to charge $25 for missed appointments.** This fee is not covered by any insurance plan and it is your responsibility.

Surgical Procedures: If after consultation with the doctor, your condition requires surgery, the procedure will be scheduled and our office will contact your insurance company to obtain benefits and preauthorization. However, verification of benefits is not a guarantee of payment from your insurance company. It is **YOUR** responsibility to contact your insurance company regarding your coverage. **Failure to keep your scheduled surgery date will result in a $200 charge, payable before your surgery will be rescheduled.**

Medicare and Insurance Plans: Your benefits will be verified and you are expected to pay the copayment, co-insurance, or out-of-pocket costs as directed by your policy. **No procedures will be performed until the full surgical deposit is paid.**

Self Insured: If you are a non-insured patient, the Financial Coordinator will estimate the cost of your surgery. You are required to pay at least 50% of the estimated charge prior to the surgery being scheduled. Upon making your down payment, the balance must be paid before the surgery takes place.

Billing Procedures: As a courtesy, our office will submit your primary insurance claim on your behalf. Therefore, it is essential that we have complete and accurate information about your insurance carrier. Please remember that your insurance policy is an agreement between you and the insurance company. It is your responsibility to pay any balance not paid or covered by your insurance. **If an incorrect or invalid insurance card is presented, you will be responsible for the billed charge for your office visit(s), surgery, and DME.**

Collection Process: Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. Our Billing Department is able to help you with any questions you may have. You will receive a statement from our office. Please understand that our services are separate from the hospital. Therefore you will receive a statement from us as well as from the hospital and other providers involved in your care.

Delinquent Accounts: If your account has no payment for 60 days and becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to a collection agency and/or credit bureau.

Forms and Medical Records: If you require our office to complete any forms for disability or work purposes, there will be a **$25 charge for each form** to be collected prior to the form being completed. Please allow 5 business days for their completion. If you require a copy of your medical records, you must sign a Medical Records Release of Information form and a payment of **$25 (for up to 20 pages) plus $0.50 per page thereafter** will be required.

I have read the financial policy and agree to its terms. _____ _____

Signature Date

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Pain Medication and Prescription Policy

Southwest Neurospine Institute can only provide pain medication for patients who require a surgical procedure. Our practice does not provide long-term pain management services. The following outlines our pain medication prescription policy.

- Patients may be prescribed pain medication during our initial evaluation and surgical preparation period, if it is felt that surgery will likely be required. If surgery is not required, the patient will be referred back to his or her primary care physician to manage pain or make additional referrals.

- I will submit to urine drug testing upon request.

- If surgery is necessary, pain medication may be prescribed prior to surgery if needed. Pain medication may also be prescribed for a predetermined period of time after the procedure is performed. During the recovery process, the amount of medication will be gradually reduced to help the patient avoid dependence on the drug.

- Pain medication can be taken as prescribed. Patients are not to increase medication dosage without consulting Southwest Neurospine Institute.

- Improper use of medications can lead to the termination of the physician-patient relationship.

- Once pain medications are prescribed by our physician, you agree that our office will **solely** manage those pain medications; in other words, you agree **NOT** to take pain medications prescribed by other physicians.

- As your doctor may not always be available in the office, please call for a refill request at least **FIVE** working days before your medication runs out.

- Requests for prescription refills can only be accepted during regular office hours. Prescriptions cannot be filled in the evenings, on weekends, or holidays because we must have access to a patient's medical records. Refill requests after noon on Friday will not be filled until the following week.

- If long-term pain management is required, the patient will be referred to a pain management physician or to his or her primary care physician. After you have been referred to a pain management clinic or other specialty, or have been released to your primary care physician, our office will no longer prescribe pain medications.

I have read and understand the above stated pain Medication and Prescription Policy for Southwest Neurospine Institute.

_____ _____

Signature of Patient or Responsible Party **Date**

Disclosure of Physician Financial Interest:

Please be advised that Southwest Neurospine Institute or one or more of its affiliates, physicians, or owners have a financial interest in one or more of the following entities.

- Foundation Surgical Hospital of El Paso/Legent Hospital
- Mountain West Surgery Center/Premier Surgery Center
- Southwest Neurospine Staffing
- Southwest Neurosurgical Consultants
- Neuron Integrity
- NeuronShield
- Innovation Neuromonitoring
- Sun City Reads
- West Texas Management
- Emlabint

You have the right to choose the provider of your health care services. Although, we believe that these entities will be able to meet your needs, you have the option to choose a facility other than the above referenced facility/company. You will not be treated differently by your physician if you choose to use a different facility or company.

DISCLOSURE AGREEMENT

I have been informed by Southwest Neurospine Institute that the physician who is rendering services has a financial or ownership interest in the above referenced facilities and companies. I understand I am free to choose another facility and/or company from which to receive the services that may be ordered by my physician.

Date: _____

Patient Signature: _____

Patient Name (printed):_____

The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and

2. In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Patient Signature: _____ Date: _____