

Thank you for choosing **DuPage Neurosurgery** as your healthcare provider.

Our goal is to provide outstanding operative and non-operative neurosurgical care to patients with disorders of the brain, spine, or peripheral nerves, as well as to patients who suffer from chronic pain. The following is a statement of our Financial Policy, which we require that you read and sign before treatment.

Please note that DuPage Neurosurgery is contracted with several insurance companies. Please check with our Reception or Billing Staff if you should have questions that directly relate to your insurance carrier.

It is our policy that we have a current photocopy of your insurance card on file. Please be prepared to show your insurance card at every visit.

Co-payments: Co-payments are expected at the time of service and will be collected prior to your visit at check-in.

Non-Contracted Insurance Plans, are considered as Out of Network: Full payment is required at the time services are rendered. (As a courtesy to our patients, we will forward all claims to your insurance company and they will reimburse you directly.)

Motor Vehicle Accident/Third Party Liability: Full payment is required at the time of service regardless of any claim or pending legal action. (As a courtesy to our patients, we will forward all claims to your insurance company and they will reimburse you directly.)

Medicare Patients: DuPage Neurosurgery's physicians are participating providers with Medicare. We accept assignment for all services provided to you. Please note that the 20% co-insurance and any deductible amount is the patient's responsibility. In the event that you carry a secondary insurance, please be sure to provide us with that information so that we can forward your claims to that carrier. Any unpaid balances will be due by you.

Workers' Compensation: We will file a claim with your employer or its insurance company as long as we have authorization that your injury is being considered a compensable Worker's Compensation claim.

Usual and Customary Rates (UCR): You are responsible for any charges deemed as over usual and customary.

Missed Appointments: In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee for any appointments missed or not cancelled at least 24 hours prior.

Past Due Accounts: Accounts with unpaid balances will be sent to our collection agency if balances are not paid in full within 90 days.

Please Note: *In the event that your insurance company refuses payment, delays payment or makes a partial payment on a claim, timely payment for the total balance due is the patient's responsibility.*

Authorization for Release of Information

I hereby authorize DuPage Neurosurgery, S.C. to release information requested by my insurance company or Worker's Compensation carrier. I also authorize DuPage Neurosurgery, S.C. to release information to any hospital, surgery center, treatment or diagnostic center or physician I may be referred to by this office.

Assignment of Benefits

I hereby represent and agree as follows: a) I represent that I currently maintain medical insurance coverage which will reimburse the charges for medical services provided; b) If my medical insurance is not sufficient to satisfy the charges in full, I acknowledge that the resulting balance is not covered by this assignment and I will be fully responsible for payment of this balance due. In consideration of these medical services, I hereby assign, transfer, and set over to DuPage Neurosurgery, S.C., all of my rights, title and interest to medical reimbursement benefits under my insurance policy (s) and/or any pending or future lawsuits, claims or actions.

Verification of Benefits

I acknowledge that I have provided DuPage Neurosurgery, S.C. with all known insurance information, which may be applicable to help expedite payments. This includes but is not limited to all insurance policies, correct insurance data, and pre-certification information.

Guarantee of Payment:

I agree, whether I sign as patient or as agent, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay that account of DuPage Neurosurgery, S.C. in accordance with the regular rates and terms of DuPage Neurosurgery, S.C.

If you should have any questions, please contact our billing department at (630) 858-5400.

Sign

Date

By signing this I thoroughly understand and agree to the terms of the above stated policy.

Treating physician: _____

Appointment Date: _____

PATIENT INFORMATION

PATIENT NAME _____ **DATE OF BIRTH** _____

HOME ADDRESS _____

HOME PHONE # _____ **STREET** _____ **TOWN** _____ **ZIP CODE** _____
BUSINESS PHONE # _____

SS# _____ **E-MAIL ADDRESS** _____

EMPLOYER _____ **OCCUPATION** _____

EMPLOYER ADDRESS _____

SPOUSE NAME _____ **DOB** _____ **SS#** _____

EMPLOYER _____ **EMPLOYER PHONE** _____

EMPLOYER ADDRESS _____

EMERGENCY CONTACT _____ **PHONE** _____

PHARMACY NAME AND ADDRESS _____

PHARMACY PHONE# _____ **FAX#** _____

PRIMARY INSURANCE

RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT _____

NAME OF INSURANCE COMPANY _____

ADDRESS _____

ID# _____ **GROUP#** _____ **PLAN#** _____

SECONDARY INSURANCE

RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT _____

NAME OF INSURANCE _____

ADDRESS _____

PHYSICIAN REQUESTING CONSULT _____

ADDRESS _____ **PHONE** _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____ **PHONE** _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

Cause of Injury

Patient Name: _____

Is the reason that you are being seen today the result of a work related injury? _____

Is the reason that you are being seen today the result of a motor vehicle accident? _____

If the answer to both above questions is NO, go to the bottom of page, date, and sign.

If your injury was the result of a work related or motor vehicle accident, please provide the following:

1. Date of injury or accident: _____

2. Complete description of injury or accident: _____

3. Do you plan to file a lawsuit? _____

4. Do you have an attorney involved in your case? _____

5. If so, please provide name, address and phone number of attorney: _____

6. Name, address and phone number of insurance company responsible for payment:

7. Name and phone number of claims adjuster and/or case manager: _____

8. Assigned case or claim number: _____

Patient Signature: _____ Date: _____

Patient Intake Form

Patient Name: _____

Date _____

Medications

Are you currently taking any medication? No Yes

If you answered yes, please list all prescription, over-the-counter and herbal medications below.

Name	Dose	How often	Additional comments

Medication Allergies

Are you allergic to ANY medication? No Yes If you answered yes, please list below.

Name of medication	Type of Reaction	Additional Comments

Previous Surgeries or Hospitalizations

Have you ever:

been hospitalized for a medical problem?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Please specify _____
had an operation?	<input type="checkbox"/>	<input type="checkbox"/>	Please specify _____
had any problems with anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	Please specify _____

Social History

Are you currently working? No Yes

Marital Status? _____

What is/was your most current occupation? _____

Are you right or left handed? _____