NORTHSTAR NEUROLOGY
of Colorado Springs

New Patient Information

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Patient name: ____ DOB: ________________________

Address/City/State/Zip: ____

Email: _____________________________________ Gender: ____ SS #: _________________________

Home phone: _________________ Work phone: _________________ Cell phone: __________________

Race: ___________________________ Preferred Language: ___________________________

Employer: ____

Name of Referring Physician: ____

Name of Primary Care Physician: ____

Responsible Party ‘Self ‘Spous e ‘Paren t ‘Other

Responsible Party Name: _________________________________ Phone: ___________________________

Date of birth: ____________________ SS#: ___________________________

In case of emergency, please notify: ____

Address: ____

Relationship: __________________________ Phone: _______________________

Insurance Information

Primary Health Ins. Co.: ____

,QVXUHG¶V1DPH 2%BBBBBBBBBBBBBBBBBBBBB 6RF6HFBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB

Relationship to Patient: ‘Self ‘Spous e ‘Paren t ‘Other

Member/Policy ID#: ______________________________ Group #: ___________________________

Secondary Health Ins. Co.: ____

,QVXUHG¶V1DPH 2% ____________________ Soc. Sec. #: ___________________________

Relationship to Patient: ‘Self ‘Spous e ‘Paren t ‘Other

Member/Policy ID#: ______________________________ Group #: ___________________________

Preferred Pharmacy: ____

Address: ____

Ph #: _________________________ Fax #: _________________________

Current Medications

Name: _____ Dosage: _____ Frequency: _____ Prescribing Physician: _____

Name: _____ Dosage: _____ Frequency: _____ Prescribing Physician: _____

Name: _____ Dosage: _____ Frequency: _____ Prescribing Physician: _____

Name: _____ Dosage: _____ Frequency: _____ Prescribing Physician: _____

Name: _____ Dosage: _____ Frequency: _____ Prescribing Physician: _____

Allergies

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Acknowledgment of Privacy Statement, Authorization and Assignment of Benefits

Privacy Statement

By signing this document, I acknowledge that I have been offered a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made known of my privacy rights.

Release of Medical Information

Should it become necessary, Northstar Neurology of Colorado Springs physicians and medical staff have my permission to discuss my health information, including test results, with the individuals listed below. The following people below also authorized to schedule, confirm, cancel or reschedule an appointment for me.

Name: _____ Relationship: _____

Phone: _____ ☐ Home ☐ Work ☐ Cell

Name: _____ Relationship: _____

Phone: _____ □ Home □ Work □ Cell

Authorization and Assignment of Benefits

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by Northstar Neurology of Colorado Springs. I request payment of government benefits, if applicable, to the party who accepts assignment. I authorize payment of medical benefits to Northstar Neurology of Colorado Springs. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of the services rendered. It is my responsibility to notify the organization of any changes in my health care coverage.

Print name: _____

(If a patient is a minor or dependent, parent or legal guardian must print name)

Signature: _____ Date: _____

(If a patient is a minor or dependent, parent or legal guardian must sign)

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No-Show, Cancellation, and Dismissal from Practice Policy

For Office Visit:

A "no-show" is someone who misses an appointment without calling 24 hours in advance. A Cancellation fee of **$50.00** will be issued for any appointment that is missed by the patient or not cancelled **24 hours prior** to the appointment. Patients will receive an invoice in the mail.

A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "no-show".

For Procedure:

Patients who do not show for their scheduled EEG procedure or fail to notify the office **48 hours prior** to the appointment will be subject to a **$75.00** cancellation fee.

Dismissal from Practice:

If the patient is a "no-show" 3 times or more in a 12-month period, they will be dismissed from the practice.

The cancellation and no-show fees are patient responsibility and must be paid in full before the patient's next appointment.

I have read and understand these policies.

Communication Consent

By providing your mobile phone number and email address to Northstar Neurology of Colorado Springs hereby referred as "Clinic" you are agreeing to be contacted by automated services on behalf of the Clinic, including emails to your email address and text (SMS) messages to your mobile phone and other wireless devices, and the use of an automatic telephone dialing system, artificial voice and pre-recorded messages, for the purpose of providing services billing and reminders by the Clinic.

You may opt-out of receiving text(SMS) messages from Northstar Neurology at any time by replying with the word STOP from the mobile device receiving the messages. You do not need to provide this consent for text(SMS)messages to receive any services from Northstar Neurology. However, you acknowledge that opting-out of receiving text(SMS) messages may impact your experience with the service(s)that rely on communications via text (SMS)messaging. I can withdraw my consent for receiving text (SMS) messages from the Clinic at any time.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

NORTHSTAR NEUROLOGY
of Colorado Springs

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you from ”surprise billing”. This is sometimes called “balance billing” and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a “CO-DOI” on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?
You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan’s network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as “outofnetwork”.

Out-of-network hospitals, facilities or providers often bill you the difference between what [Carrier] decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called ‘surprise’ or ‘balance’ billing.

When you CANNOT be balance-billed:
Emergency Services
When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan’s in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balanced-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency services at an In-Network or Out-of-Network Facility
The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your innetwork costsharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly. Again, you are only responsible for paying your in-network cost-sharing for covered services.
- Your insurer will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.

- Your provider, hospital, or facility must refund any amount you overpay within 60 days of you reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

If you do receive a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at 303-894-7490 or 1-8009303745.

Ambulance Information: You may be balance billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by your insurance, you may receive a balance bill.

Signature _____ Date: _____

Patient Name : _____ DOB: _____