

ASSOCIATED NEUROLOGICAL SPECIALTIES  
AUSTIN EMG CAPITOL EEG  
900 West 38<sup>th</sup> Street, suite 350

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please...read, initial, and sign below.

(Initial) \_\_\_\_\_ **FINANCIAL RESPONSIBILITY:** I understand that I am ultimately responsible for payment on my account. **Payment is expected at the time of service.**  
I understand that **I am responsible for any Referral or Authorization that my insurance may require.**  
I understand that I am responsible for any charges not covered by my insurance plan, including Co-payments, Co-insurance, and Deductibles.  
Claims will be filed for PPO and HMO participants and Medicare. Payment of benefits will be made directly to Associated Neurological Specialties.

(Initial) \_\_\_\_\_ **INSURANCE COVERAGE:** I understand that I am responsible for providing ANS with **any and all insurance coverages at each and every visit.** I will be responsible for any balances due as a result of not disclosing this information.

(Initial) \_\_\_\_\_ **INSURANCE PROVIDER:** I certify that \_\_\_\_\_ is my primary insurance provider.

**SECONDARY INSURANCE PROVIDER: Please circle and initial one of the following:**

(Initial) \_\_\_\_\_ I certify I do have a secondary insurance policy. I also understand that ANS will not file my secondary insurance, except in the case of Medicare. **AND** Upon my request, they will provide me the paperwork necessary to obtain reimbursement directly from my insurance, unless prior arrangements have been made with our billing department.

**-OR-**

(Initial) \_\_\_\_\_ I certify I do **NOT** have a secondary insurance policy.

(Initial) \_\_\_\_\_ **HIPPA:** I acknowledge that I have received a copy of ANS' Notice of Privacy Practices.

(Initial) \_\_\_\_\_ **FEE FOR FORMS COMPLETION:** I understand there will be a charge for any forms I bring to be completed by ANS physicians or staff. (Example: Disability forms, FMLA forms, etc.). I will be required to schedule a re-visit with the doctor to discuss these forms and there will be a charge of \$18.00 for their completion. I understand it is my financial responsibility, not my health plan's responsibility, to pay this. Forms will not be completed until this fee is paid.

(Initial) \_\_\_\_\_ I understand that when I call this office, **I may or may not be able to speak with a live person right away.** I understand that if I am having a **medical emergency, I should not call this office, but should call 911.** When calling this office about a medical question, I am aware that the doctors are very limited by my report and are limited in what they can observe over the phone. **If I have new symptoms, worsening symptoms, and unexplained symptoms, I understand I should present to the emergency room immediately for an evaluation.** I will then need to schedule a visit with the doctor, so that he can review my questions and concerns thoroughly. **I understand not all of my calls can be answered, due to time and personal constraints.**

(Initial) \_\_\_\_\_ I understand that a \$25 "no show" fee will be assessed for appointments I do not keep and have not called within 24 hours of the appointment to cancel.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

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