Alamo Neurosurgical Institute

ALAMO NEUROSURGICAL INSTITUTE
414 W SUNSET, SUITE 205
SAN ANTONIO, TEXAS 78209
WWW.ANI-ONLINE.COM

OFF: 210.564.8300 FAX: 210.564.8399

ANI FINANCIAL POLICY

Thank you for choosing *Alamo Neurosurgical Institute* as your health care provider. We are committed to your treatment being successful. Please understand that payment of your account is considered a part of your treatment. The following is a statement of our financial policy which we ask that you read, agree to, and sign prior to any treatment.

INSURANCE: Our physicians accept Medicare, Tricare, and PPO insurance plans. Insurers may require authorization from your primary doctor, prior to seeing a specialist. It pre-authorization is required you must get that insurance authorization prior to your appointment with us. We will not file with MVA/auto insurance, and we do not accept attorney "Letter of Protection".

CO-PAYS: Your co-pay and deductible are due at the time of service.

USUAL CUSTOMARY CHARGES: Our practice is committed to providing the best treatment possible for our patients. We charge usual and customary fees for the services that we provide, however our fee schedule may differ from the usual and customary charges that your insurance company has approved. While every effort is made to work with your insurance company to limit the amount you may owe, you are responsible for paying the remainder of the balance that the insurance does not pay.

APPEALING DENIED CLAIMS: I hereby authorize *Alamo Neurosurgical Institute* as a Designative Representative to appeal all claim on my behalf. In the event your claim is denied we will make every effort to work with your insurance company to limit the amount you may owe. (For more information reference ANI Financial and Privacy Policy)

SURGERY FINANCIAL ARRANGEMENT: Many patients referred to *Alamo Neurosurgical Institute* require surgical treatment. If surgery is indicated, we will pre-certify your surgery with your insurance carrier. The patient portion of the services is payable upon receipt of initial bill unless other arrangements have been made. In the event that your insurance fails to cover the charges for the services rendered, you may be responsible for some or all of the charges.

ASSIGNMENT OF BENEFITS: I hereby assign to *Alamo Neurosurgical Institute* and insurance or other third-party benefits available for health care services provided to me. I understand that Alamo Neurosurgical Institute has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Alamo Neurosurgical Institute, I agree to forward to the practice all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST: In the course of your treatment you may be referred to an entity to assist in your care that Dr. Leonard has a financial interest in. These entities may or may not include:

- Foundation Surgical Hospital
- Select Neuromonitoring Consultants

It is important for you to know that these entities may or may not be in-network with your insurance. You are encouraged to contact these companies to discuss any billing questions you may have. It is your right to request not to utilize any of the above named companies in Dr. Leonard's treatment of you. He will be happy to attempt to arrange to use another facility for your treatment or alternatives to the above services if this is your wish and if he believes such a treatment option to be medically appropriate for you.

ADDITIONAL DOCUMENTS AND FORMS: The following additional In the documents/forms will acquire a prepaid fee for the services rendered. Documents/Forms will not be filled out until prior payment in full has been made. Please see below fees.

- Short and Long Term Disability Forms $50
- Injured Employee Counsel Documents $50
- Copies of Billing/Medial Records $18 - $50
- Narrative Reports $500

Print Patient Name _____ Date of Birth _____

Signature of Patient (or Patient Guardian/Representative) _____ Date _____

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SUMMARY NOTICE OF ANI FINANCIAL AND PRIVACY POLICY

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction
At Alamo Neurosurgical Institute, P.A., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective August 16th, 2004, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information
Each time you visit Alamo Neurosurgical Institute, P.A., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Alamo Neurosurgical Institute, PA., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
Alamo Neurosurgical Institute, P.A. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Understanding Appealing Claims and Assignment of Designation of Authorized Representation
Due to the facts that my claims in a significant amount for medically appropriate health care has been improperly denied by my insurance/health plan, and I will be in financial hardship or disturbance and medical indigence in paying for such significant amount of medical expenses at this time, I hereby designate my healthcare provider listed above to take all necessary steps, as my authorized representative on my behalf, to pursue administrative or judicial appeals, internal or external, in order to seek reimbursement payments for my medical expenses that I am otherwise legally entitled to under the terms of my insurance/health plan. I would like to make this designation and authorization absolutely clear and to the fullest extent permissible under applicable federal and state laws, for my authorized representative to pursue and appeal a benefit determination under my insurance/health plan, to act and to directly receive reimbursement payment checks, notices and any applicable judicial remedies, on my behalf with respect to my significant balance for this medical claim. In the absence of a contrary direction from myself, my insurance/health plan must comply with applicable federal and state laws by directing all information and notifications, to which I am otherwise legally entitled to under the terms of my insurance/health plan and applicable federal and state laws, including but not limited to, the Employee Retirement Income Security Act (ERISA), the Patient Protection and Affordable Care Act (PPACA) to my authorized representative, as listed above, authorized to act on my behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, SPD and remedies, reimbursement checks, etc.).

Both federal and state laws protect my rights to appeal for improper denials for my medically appropriate health care, especially in this case with such a significant balance in my account. The applicable federal laws specifically prohibit anyone from precluding or interfering with my rights to designate, to assign my healthcare provider as my authorized representative to exercise such protected right in helping me in this regard of medical and financial security because my healthcare provider has better knowledge and skills in medical science, clinical experience, billing and coding terminology in healthcare delivery industry.

Time is the essence, and the applicable federal laws require prompt verification procedure completed and response to my appeal in 30 days and no more than 45 days if you need additional information. If you have any questions regarding this authorization, please act so within timeline as mandate by federal laws. Failure to adjudicate my claims and my appeals as required by federal law may impose more financial hardship on me and negatively affect my credit profile, more dangerously; refusal to pay my account improperly will discourage me or prevent me from seeking prompt medically necessary care for my current and future medical conditions.

For More Information or to Report a Problem
If have questions and would like additional information, you may contact the practice's administrator at the office.

If you believe your privacy rights have been violated, you can file a complaint with the practice's administrator or with the Office for Civil Rights, U. S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services 200
Independence Avenue, S.W.
Room 509F, HHH Building Washington,
D.C. 20201

We will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. Include but are not limited to the following:

- **Business Associates:** There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Directory:** Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.
- **Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
- **Communication with Family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
- Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- **Funeral Directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
- **Organ Procurement Companies:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- **Marketing:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- **Workers Compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- **Public Health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- **Law enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Please Complete the Acknowledgment of Receipt
Alamo Neurosurgical Institute, P.A.
Summary of Financial and Privacy Practice Act

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ACKNOWLEDGEMENT RECEIPT
ALAMO NEUROSURGICAL INSTITUTE, PA
FINANCIAL AND PRIVACY POLICY NOTICE

I hereby acknowledge that a copy of *Alamo Neurosurgical Institute, P.A.* Notice of Financial and Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about *Alamo Neurosurgical Institute, P.A.* financial and privacy practices or my rights with regard to my personal health information, I may contact an *Alamo Neurosurgical Institute, PA* representative for further information as set forth in the Notice.

_____ _____
Name of Patient - Please Print Name Date of Birth

_____ _____
Signature of Patient (or Patient's Representative) Date

If signed by patient's personal representative, state representative's authority to act on behalf of patient.

SUPPORTING GOOD FAITH EFFORT TO OBTAIN
ACKNOWLEDGEMENT OF RECEIPT ANI'S
FINANCIAL AND PRIVACY PRACTICE NOTICE

Patient Name:_____ Patient Identification #:_____

I hereby certify that on _____/_____/_____ (MM/DD/YY), I made a good faith effort to obtain the above patient's written acknowledgment of receipt of *Alamo Neurosurgical Institute, P.A.* Notice of Financial and Privacy Practices, but I was unable to do so for the following reason(s)

_____

_____

_____

_____ _____
Name of Staff (print name) Signature of ANI Staff

_____
Date

THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.