Alamo Neurosurgical Institute
Michael A. Leonard, MD
414 W SUNSET RD, SUITE 205, SAN ANTONIO, TX 78209
www.ani-online.com | Office: (210) 564-8300 | Fax: (210) 564-8399

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

EXPLANATION: This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act.

Patient Name:_________________________ DOB:_____________ SSN:__________________

INFORMATION TO BE RELEASED TO:

Alamo Neurosurgical Institute
Michael A. Leonard, MD
414 W. Sunset Road, Suite 205
San Antonio, Texas 78209
Phone: (210) 564-8300
Fax: (210) 564-8399

INFORMATION TO BE RELEASED:

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I am aware of and/or have been advised of the provisions of existing State and Federal Statutes, Rules and Regulations which provide for my right to confidentiality of the information in these records.

I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization before any records can be released, also that I may refuse to sign, but in that event the records cannot be released.

Signature:____ Date:_____________

Signature of parent/guardian: (If minor)_____________________________________

Relationship to patient:____

ANI SPINE + BRAIN SURGERY

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HIPAA RIGHT OF ACCESS FORM

According to the Federal government privacy rules implemented by The Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order for Alamo Neurosurgical Institute's healthcare provider and/or staff member to discuss your medical condition and treatment plan with family members and/or any other individuals designated by you, we must obtain your authorization prior to doing so. You have the right to revoke this consent at any time, except where we have already made disclosures in reliance on your prior consent. All changes must be made in writing and submitted to our office.

__________ I **do not** authorize Alamo Neurosurgical Institute, to release information pertaining to my medical care/treatment to any individual.

__________ I **do** authorize Alamo Neurosurgical Institute, to release any/all information pertaining to my medical care/treatment to the individual(s) listed below.

______________________________	____________________
Name / Relationship	Phone Number
______________________________	____________________
Name / Relationship	Phone Number
______________________________	____________________
Name / Relationship	Phone Number
______________________________	____________________
Name / Relationship	Phone Number

______________________________	____________________
Patient Name	Date of Birth
______________________________	____________________
Patient Signature	Date

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RADIOLOGY CONSENT FORM

Radiologic procedures can cause serious birth defects, mental retardation and even death to an unborn fetus, especially during the first 3 months of pregnancy. Please answer the following questions to rule out the slightest possibility of pregnancy.

Name:____

Date of Birth:____________________________ Age:____________

Beginning of last menstrual period:____________/____________/____________
Month Day Year

Have you had unprotected intercourse since your last period? ❑ Yes ❑ No

Are you using any type of contraception? ❑ Yes ❑ No

Birth Control Pills	❑ Yes	❑ No
Hysterectomy	❑ Yes	❑ No
Tubal Ligation	❑ Yes	❑ No
Partner Vasectomy	❑ Yes	❑ No
Condom and Foam	❑ Yes	❑ No
Sponge	❑ Yes	❑ No
IUD	❑ Yes	❑ No
Diaphragm	❑ Yes	❑ No

Could you be pregnant? ❑ Yes ❑ No

I have read and understand the above information and give my authorization for x-rays.

______________________________ ______________________
Patient Signature Date

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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. If pre-authorization is required, you must get that insurance authorization prior to your appointment with us. We will not file with third party auto insurance and/or motor vehicle accidents.

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
- Select PA Solutions

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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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.

______________________________ ______________________________
Print Patient 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)

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____

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______________________________ ______________________________
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