

**JAIN HAND SURGERY CENTER
INSURANCE INFORMATION
BILLING POLICY**

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH _____

INSURANCE INFORMATION

SPOUSE OR PARENT NAME (IF NOT PATIENT) _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ EMPLOYER _____ PHONE _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____ CITY AND STATE _____ ZIP _____

NAME OF INSURANCE COMPANY _____ ID NUMBER _____ GRP NUMBER _____

AUTO INSURANCE

INSURANCE COMPANY _____ PHONE # _____ DATE OF ACCIDENT _____

EMERGENCY CONTACT

NAME _____ PHONE NUMBER _____

BLUE CROSS AND BLUE SHIELD PATIENTS ONLY

PLEASE READ AND SIGN STATEMENT BELOW:

I DO NOT HAVE MEDICAL INSURANCE BENEFITS AVAILABLE TO ME THROUGH OTHER HEALTH INSURANCE COMPANIES.
BCBS IS MY ONLY HEALTH INSURANCE COMPANY.

SIGNATURE OF POLICY HOLDER /SPOUSE _____

DATE _____

BILLING POLICY

IF YOU DO NOT HAVE INSURANCE:

Patients who do not have insurance are responsible for their bills themselves and are expected to pay for our services as it is rendered. Any balance due is expected the day of service unless prior arrangements have been made.

IF YOU DO HAVE INSURANCE:

For your convenience, we will bill your insurance company for 100% of all charges incurred by you. We allow 30 days from the date of your first treatment for your insurance company to pay. If a payment is not received we will contact you for your billed amount. Remember, you purchased your insurance policy and you are responsible for any and all claims. We will be happy to assist you in any way possible should you have any questions.

ADDITIONAL INSURANCE FORMS:

Forms such as disability, personal injury claims, etc., can be completed as requested by our insurance department. We must be given five(5) working days for completion and there is a charge for this service.

MEDICAID/WORKERS' COMPENSATION:

We will need proof or verification of this status. This must include but, not limited to: As long as you are being treated by this office and remain covered by the Medicaid program you should never receive a bill from this office, except for copay as set forth by Medicaid. Workers' Compensation requires proof of claim, verification of claim and authorization. If for any reason your claim is denied by your Workers' Compensation company you will become immediately responsible for any payments not made by Workers' Comp. You will be billed for balance due at the time of your denial and future visits. Failure to comply can result in added attorney fees or referral to a collection agency.

I UNDERSTAND AND COMPLY WITH THIS POLICY

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

- Physician Insurance Assignment; I, the subscriber, hereby authorize payments directly to the treating physician or surgeon herein specified for his services. For Auto insurance patients please list the name of the Auto insurance company below and sign, assigning and authorizing All payments for medical care to be assigned and released to Dr. Jain only. I relinquish all benefits available to me for self income/salary.
 - Medicare/Medicaid; I certify authorization to release information to the specific doctor applying for payment under title XVIII/XIX of the Social Security Act. I hereby certify all insurance pertaining to my treatment should be assigned to Dr. Vidya S. Jain.
 - I permit a copy of these authorizations and assignments to be used in place of the original which is on file.
 - I agree that should the amount of the insurance payment be insufficient I will be responsible for payment of the difference.
- I have read the above statement and understand them fully.

Date _____

Signature _____

Auto Insurance Company Name _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Jain Hand Surgery Center

I understand that as part of my healthcare, Jain Hand Surgery Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professional whom contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- And a toll for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Jain Hand Surgery Center reserves the right to change its notice and practices, and prior to implementations, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax

I fully understand and accept/decline the terms of this consent

Patient/Parent/Legal Guardian Signature

Date

FOR OFFICE USE ONLY

- { } Consent received by _____ on _____
- { } Consent refused by patient, and treatment refused as permitted
- { } Consent added to the patient's medical record on _____