

BLACK HILLS NEUROSURGERY & SPINE

NEUROSURGICAL & SPINAL SURGERY ASSOCIATES, P.C.

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Toll-free: 800-253-5876

Dear _____: Welcome to Black Hills Neurosurgery & Spine. We look forward to seeing you at your appointment with:

Neurosurgeons: Dr. Rice Dr. Seljeskog Dr. Watt: on: _____ at: _____
Date Time
Neurologist: Dr. MacLachlan: in: _____
Location

When you come to your appointment – **Please bring the items marked below:**

1. **MRI – the CD or actual films and report**
2. **CT Scan – the CD or actual films and report**
3. **X-rays – the CD or actual films and report**
4. **Any medical records that pertain to your present condition**
5. **Other diagnostic reports pertaining to your present condition including lab reports, any recent EKG, EMG or Chest X-ray**
6. **If you are taking medication, please bring a list of your current medications including medication names, dosage and frequency of use.**

We have enclosed several forms for you to complete. Please take your time completing them and bring them with you to your appointment along with your insurance card(s).

WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT IF YOU FORGET ANY OF THESE ITEMS

YOUR APPOINTMENT

We make every attempt to schedule appointments for the convenience of our patients. Sometimes appointment schedules change because an emergency or a prolonged surgery requires the physician's continued presence. Circumstances like these occasionally cause all or part of the day's appointments to be rescheduled. If this should happen, we will reschedule your appointment at the earliest time available. Please help us serve you and our other patients better by keeping your scheduled appointment. We ask that you notify our office at least 24 hours in advance if you wish to reschedule your appointment. However, if weather conditions are difficult on the day of your appointment, we encourage you to call and reschedule your appointment rather than risk travel.

OUR FINANCIAL POLICY

Our patients without health insurance coverage are considered self-pay and payment in full is due at the time of service. We accept cash, check or credit card. If you have insurance other than Medicare you will be required to pay your co-pay, deductible and co-insurance at the time of service. If you do not know these amounts we ask you to pay a minimum of \$25.00 for your visit. If you are a Medicare patient with supplemental coverage you will not be required to pay at the time of service. If you have Medicare coverage without a supplement you will be required to pay your deductible and the 20% co-insurance based upon the Medicare fee schedule.

If you are a Medicaid patient you must have a referral from your primary care provider. You must also pay your co-pay at the time of service. If you do not bring your referral and pay your co-pay your appointment will be rescheduled.

Patients covered by Indian Health Services must obtain prior authorization from the Contract Health Services department at their IHS facility.

Please bring your insurance card(s) with you to your appointment and provide us with complete insurance company information, including phone numbers and addresses. We will not bill your insurance company until you provide us with a copy of your insurance card. Many insurance companies require prior authorization before obtaining care from a specialist. You are responsible for obtaining this authorization prior to your appointment. If your insurance policy has this requirement, you must bring that paperwork or authorization with you to your appointment. We will submit a claim to your insurance company on your behalf however; we will not be responsible for disputes between you and your insurance company other than to provide information regarding your claim for services. **If we are not a participating provider with your insurance company you will also be responsible for any non-allowed or non-covered charges. You are responsible for determining if our physician's are participating providers with your insurance company prior to your appointment.**

If, for any reason, you feel you will not be able to pay at the time of your appointment or if you need information about the cost of your care, please contact our patient accounts department prior to your appointment at (605) 341-2424 or 1 800-253-5876.

WORKERS COMPENSATION

If your visit will be paid for through a workers compensation claim, you must have your worker's compensation insurer contact us with an authorization and guarantee of payment prior to your appointment. If you fail to obtain authorization your appointment will have to be rescheduled.

MOTOR VEHICLE ACCIDENTS/PERSONAL INJURY LAWSUITS

If your appointment is the result of a motor vehicle accident or personal injury or if you have current litigation in process, you will still be responsible for payment at the time of your visit. We will not submit claims on your behalf to a third party payer. We will only submit claims to your own motor vehicle or personal insurance plan. Please bring your insurance card(s) with you should you choose to use your private health insurance as a back-up to your motor vehicle insurance.

SURGICAL FOLLOW-UP

If you have surgery, your office visits following surgery are included in the cost of the surgery for up to 90 days. This does not include post-op X-rays, other diagnostic tests, other necessary procedures or visits for problems not related to your surgery. Should your surgeon continue to see you after 90 days you will be charged a fee for these appointments.

PHYSICIAN ASSISTANTS

Our surgeons use physician assistants specialized in neurosurgery to assist in most surgical cases. Most of the time insurance companies pay for the services provided. However, in the instances where they do not you may be responsible for these charges. Please check with your insurance company if you are unsure about their payment guidelines regarding physician assistants.

INTRAOPERATIVE MONITORING SERVICES

Our surgeons may use intraoperative monitoring during surgery to provide information concerning the functioning of your nervous system. If these services are provided there will be a separate charge for them. Please ask, if you have questions about these services.

DISCLOSURE OF PHYSICIAN OWNERSHIP

Neurosurgical & Spinal Surgery Associates, P.C., Black Hills Neurosurgery & Spine, Neurology Associates and/or its physician's have either a partial or entire ownership interest in Promotion Physical Therapy (PPT), Electrodiagnostic Services (EDS), The Black Hills Surgical Hospital (BHS) and the Black Hills Imaging Center (BHIC). You have the right to choose the provider or facility for your health care services. Therefore, you have the option to use a health care provider or facility other than PPT, EDS, BHS, or BHIC for services prescribed by us. You will not be treated differently if you choose to obtain health care services at a facility or provider other than PPT, EDS, BHS or BHIC.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices outlines our obligations to you under federal privacy law. Your signature on our patient registration form will authorize our use of your personal health information (PHI) to carryout treatment, payment and health care operations activities under state laws. The phone number(s) and address you provide us will be used to contact you for appointment reminders, medical follow-up, questions regarding account information, billing and insurance claims questions, mailing account statements and other contacts unless you tell us otherwise. **In addition, we ask you to let us know to whom you will allow access to your medical records, account and/or billing information.** We may ask you to complete an authorization for release of medical information if there are any questions or concerns.

SUMMARY

If you have questions regarding your appointment, our financial policy or anything else set forth in this welcome letter and notice; please call us at (605) 341-2424, toll-free at 800-253-5876 or via email at admin@nssa.com. Your understanding is important. We ask that you contact us before your appointment if you have any questions or anticipate any problems.

I HAVE READ, UNDERSTAND AND AGREE TO THE CONTENTS OF THIS NOTICE.

Patient/Responsible Party Signature _____ **Date** _____