M. Lawrence Drerup, M.D.
Troy M. Vaughn, M.D.
Gregory C. Dowd, M.D.
Stephen D. Downs, M.D.

Alexandria Neurosurgical Clinic

A Professional Medical Corporation

3704 North Blvd., Suite C
Alexandria, LA. 71301-3606
(318) 443-4576

PATIENT REGISTRATION FORM

Date ____________

Name ______________________________ Email ______________________

Address ______________________________ City ____________ State ____ Zip ________

S.S. # ________________ Home Phone ______________ Cell Phone ____________

Sex _____ Age _____ Date of Birth __________ Marital Status __________ Spouse __________

Employer ______________________________ Work Phone ______________

Address ______________________________ City ____________ State ____ Zip ________

Referred By ____________________ Primary Care Doctor ____________________

Drug Allergies ____________________ Pharmacy/Location ____________________

****Billing: Please complete this section if person responsible for the bill is other than the above patient****

Name ______________________________ Relationship to Patient ______________

Address ______________________________ City ____________ State ____ Zip ________

S.S. # ________________ Home Phone ______________ Cell Phone ____________

Employer ______________________________ Work Phone ______________

Address ______________________________ City ____________ State ____ Zip ________

Insurance Information

Type of Insurance: ( ) Medicare ( ) Medicaid ( ) Champus ( ) Blue Cross ( ) Workers Comp ( ) Other

Please give us all of your pertinent insurance information. If you have more than one policy we need the information on both carriers.

If your coverage requires a second opinion or pre-admission approval it is your responsibility to inform us.

Primary Insurance ____________________ Secondary Insurance ____________________

Address ____________________ Address ____________________

Insured Name ____________________ Insured Name ____________________

Policy # __________ DOB: ________ Policy # __________ DOB: ________

Contract # __________ Group # ________ Contract # __________ Group # ________

Workers Comp Carrier ____________________ Do you have an attorney? ____________

Address ____________________ Name ____________________

Phone __________ Accident Date ________ Address ____________________ Phone ________

I have received a paper copy or reviewed on the website the clinic's Notice of Privacy Practices and Credit Policy.

____
Signature

Authorization for individual to obtain medical information from Alexandria Neurosurgical Clinic

This form is intended to allow our patient's the opportunity to list relatives or friends as representatives that may speak to our staff on the patient's behalf.

In an effort to protect patient privacy the patient must give permission for specific individuals to speak to our office staff on the patient's behalf. This notice will be kept in the patient's chart from the date of receipt. It is the duty of the patient to update this form accordingly in the event of necessary changes. Without written notice of a change in authorized persons, the employees of Alexandria Neurosurgical Clinic have authority to transfer requested information to the listed individuals by phone, mail, fax, etc. after verification of claimed person is established and matches the listed individuals.

Please note: A patient is not obligated to list any individual on this form. If the patient chooses not to list any individuals, our office staff will not be able to give any information about the patient for any reason. (This excludes other physicians, insurance companies, etc.)

Name (please print)	Relationship
______________________	______________
______________________	______________
______________________	______________

By signing below, I authorize the listed individuals to obtain information about my personal health records. I understand that this notice will stay in effect until I make written notice of change for documentation in my file.

______________________ Patient Signature

______________ Date

______________________ Printed name of Patient

______________________ Signature of Employee Receiving Notice

______________ Date

______________________ Printed name of employee

04/23/14 kh

Neurological Surgery
M. Lawrence Drerup, M.D., FACS, FICS
Troy M. Vaughn, M.D., FACS
Gregory Dowd, M.D.

Family Practice
Stephen D. Downs, M.D.

Administration:
Penny Allemand,
Office Manager
Kassandra Hooter,
Finance Manager

OFFICE POLICY
Stephen Downs, M.D.

1. Request for prescription refills are taken on Monday through Friday, 8 a.m. to 12 noon. Only exceptions are in cases of medical emergencies. No prescriptions will be refilled at night, on weekends, or holidays. At least 2 days notice should be given for refill requests. An attempt will be made to refill medications on the day requested; however, it may take 24 to 48 hours to refill medications. DO NOT repeatedly call the office to check the status of your refill. It is usually better to check with your pharmacy to see if the prescription has been refilled before calling the clinic. Most narcotics must be a written and signed prescription, so please make allowances for refills as you will have to come pick them up.

2. There is a $20.00 charge for all forms to be filled out by Dr. Downs. It must be paid in advance, by <u>cash</u> only.

3. In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointment and arrive in a timely manner, 10-15 minutes prior to your scheduled appointment time. If you need to cancel or reschedule an appointment, we require 24 hours minimum notice. "Missed Appointments" or last minute cancellations leave empty appointment times, as well as other patients waiting to receive medical care. For that reason, patients that do not notify the office of a cancellation, or do not show up for an appointment, will be charged a cancellation fee as follows:

   Less than 24 hours notice and Missed Appointments - $20.00 cash only

   We realize that on a rare occasion, emergencies may arise and we will address these situations with you at this time.

   We thank you for working with us to ensure services are provided to you in the best possible way.

Acknowledgement of Office Policies

Your signature on this document indicates your understanding and acceptance of our office policy. If you should have any questions regarding the policy, Dr. Downs' office will be happy to discuss them with you.

Patient Name:______________________________ Date:____________________________

Signature:____

3704 North Blvd., Suite C • Alexandria, Louisiana 71301-3606
Ph: (318) 443-4576 • Toll (800) 348-0415 • Fax: (318) 449-5579 • www.alexneuro.com

Credit Policy

To avoid misunderstanding, our Credit Counselor invites early discussion of financial problems or questions regarding fees, payment from insurance carriers, etc. General requirements for maintaining your account in good standing are as follows:

1. All charges are due and payable within 30 days of the first billing.
2. Under certain circumstances a payment in advance may be required.
3. Other circumstances may warrant an extended payment plan. Our Credit Counselor will assist you in these special instances at your request.

Office Visit Co-Payments:
Office visit co-payments are collected at the time the services are provided. Please refer to your insurance ID card or contact your health plan to verify your co-payment responsibility.

Surgical Procedure Co-Pays:
If you are scheduled for a surgical procedure, you will be required to pay a deposit prior to the procedure. Our Credit Counselor will provide you with a statement of your estimated financial responsibility and answer any questions you may have. It payment is not received prior to your surgery date, your procedure may have to be re-scheduled.

Insurance:
We cannot accept the responsibility of negotiating claims with insurance companies or other persons. It is your responsibility to provide accurate insurance information. You are also responsible for payment of your health care within a reasonable time - regardless of the status of the claim. In circumstances where a claim is pending or when treatment will be for an extended period of time, it is recommended that a payment plan be initiated.

Private Insurance: please provide our office with all insurance information including your insurance card(s). If you are not the primary cardholder for your insurance we will need the primary cardholder's name, address, date of birth and social security number.

Workers' Compensation: if your visit is covered by Workers' Compensation, please verify the information we have in your file is correct and your visit has been approved by your adjuster.

Automobile/Third Party Liability: If your visit is covered by an auto or other insurance policy, please provide us with the name and number of the insurance responsible for your visit.

Legal: our office accepts legal cases on a case by case basis. Please provide our office with the name, address and phone number of your attorney. Your visit must be approved by the physician's staff and your attorney prior to receiving services.

Reduction or Rejection of your Claim:
Your insurance policy is a contract between you and your insurance company. It is important to understand its provisions. We cannot guarantee payment of your claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

Billing:
An itemized statement covering all health care services received will be mailed to you on a monthly basis. Payment in full is due within 30 days. Charges and payments for services received during the last few days before your billing date may appear on the following monthly statement.

By my signature on the patient registration form I attest I have read the above Credit Policy and understand and agree with its terms. I also authorize the release of the medical information necessary to process my claim with my insurance company and authorize my insurance company to pay directly to Alexandria Neurosurgical Clinic the amount due me in my pending claim for medical/surgical treatment for me or my beneficiary of this policy. I understand I'm financially responsible for any balance not covered by my insurance carrier.

Neurological Su
M. Lawrence Drerup, M.D., FACS
Troy M. Vaughn, M.D.,
Gregory Dowd

Family Pr
Stephen D. Downs,

Administr
Penny Allemand, CPC,CPPM - Office Ma

Patient Name: ______________________________ Date: ____________________

DOB:_________________

Do you have an Advanced Directive: Yes______ No_______

If yes, please check all that apply:

____ Do Not Resuscitate

____ Do Not Resuscitate not on file in our office

____ Living Will on file

____ Living will not on file in our office

____ Power of Attorney on file

____ Power of Attorney not on file in our office

Please note, if you mark that you have an Advanced Directive not on file in our office, you must bring it to your next appointment so we can have a copy in your chart

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