



The Longstreet Clinic, P.C.  
A Multi-Specialty Practice

## FINANCIAL POLICY

- We participate in most insurance plans, including Medicare and Medicaid.
  - We do not file to general liability or homeowner's insurance.
- You and your insurance company are responsible for your bill.
  - Knowing your insurance benefits is your responsibility.
  - Any questions concerning your coverage should be directed to your insurance company.
- If your primary insurance company requires a co-payment, you must make the co-payment at time of service.
  - Failure to pay your copay at time of service will result in a billing fee of \$25.00. *Please remember that we are contractually obligated by your insurance company to collect your copay at time of service.*
  - The balance of your charges will be billed. Payment in full of patient portion will be expected with receipt of your statement.
- Proof of current, valid insurance must be provided at time of service.
  - If you do not provide this information, you will be considered a self-pay patient.
  - Self-pay patients are required to make an advance payment on their office visit charge. The advance payment amount will be based on the services provided. *Please ask about your advance payment responsibility when making your appointment*
  - Failure to pay your advance payment at time of service will result in a billing fee of \$25.00.
  - You will be billed for the balance of your charges. Payment in full will be expected with receipt of your statement.
- Failure to receive your statement does not relieve you of your financial obligation. It is your responsibility to notify us of any changes in your billing information.
- We accept cash, checks, money orders and major credit cards.
  - Returned checks are subject to a \$25.00 return check fee.
- Past due accounts are subject to our collections process.

\_\_\_\_\_  
Patient Name (or responsible party)

\_\_\_\_\_  
Date

# ACCIDENT INFORMATION SHEET

ONLY fill this out if the reason you are being seen is due to an accident. Please print.

Patient Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Where accident happened: \_\_\_\_\_

Please describe details of accident: \_\_\_\_\_

Is there any other insurance involved:     YES         NO

If yes, please list complete policy information: \_\_\_\_\_

To the best of my knowledge this information is accurate in regards to this accident.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# NEUROSURGERY MEDICAL HISTORY

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ DATE \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

DRUG ALLERGIES \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

WHAT PHARMACY DO YOU USE? \_\_\_\_\_

## CIRCLE ANY OF THE FOLLOWING THAT PERTAINS TO YOU

Bleeding Tendency

Hiatal Hernia/Ulcer

Blurred or Double Vision

High Blood Pressure

Bone Disease/Osteoporosis

High Cholesterol

Cancer

Lung Disease

Diabetes

Kidney Disease

Dizziness/Lightheadedness/Fainting Spells

Rheumatic Fever

Heart Disease or Heart Attack (Please specify)

Stroke

Swelling, Numbness, Tingling, Burning or Weakness of Arms or Legs

If any of the above conditions pertain to a family member please list what and whom:

\_\_\_\_\_  
\_\_\_\_\_

o List all past surgeries: \_\_\_\_\_

o Do you currently use tobacco? Y / N If yes, how much? \_\_\_\_\_ and how long? \_\_\_\_\_

o Do you consume alcohol? Y / N If yes, how much? \_\_\_\_\_

o What other doctors have you seen for this problem? \_\_\_\_\_

o Have x-rays been taken? \_\_\_\_\_ If yes, where? \_\_\_\_\_

o Have you been to the emergency room for this problem? Y / N

If yes, where \_\_\_\_\_ and when \_\_\_\_\_

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# THE LONGSTREET CLINIC, P. C.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (Name of patient) \_\_\_\_\_, acknowledge and agree that I have received a copy of The Longstreet Clinic, P. C.'s Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Legal Representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Representative

\_\_\_\_\_  
Relationship to patient

### FOR CLINIC USE ONLY:

The Longstreet Clinic, P. C. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of TLC staff member

\_\_\_\_\_  
Date