

Epstein Neurosurgery Center, LLC
Epstein Neurosurgery Foundation, Inc. 501(c)(3)
Clara Raquel Epstein, MD, FICS
 Neurosurgeon/CEO
www.epsteincenter.com
www.epsteinfoundation.org

Administrative Office:
 6940 N. 63rd Street
 Longmont, CO 80503-8852
 Phone: 303.800.9129
 Fax: 720.638.0497

PATIENT NAME _____ DATE OF BIRTH ____/____/____

Practice Policies

Thank you for choosing **Epstein Neurosurgery Center (ENC)** for your neurosurgical health care. You have been referred by your primary care or other health care provider for a consultation regarding neurological surgery and for an opinion on whether surgery is an appropriate option for your care. Our neurosurgeons and health care team are committed to providing state of the art surgical treatment and post-operative care. We are a specialty practice, and in addition to providing you with the best possible care, we believe your expectations will be best served by knowing and following our practice policies. Please read our practice policies and indicate your understanding and agreement by **initialing in the space provided next to each policy and sign and date the last page. Because this is required before you are seen by our providers, please come prepared by completing this document in advance. Your appointment may be delayed or cancelled until we have your signed understanding.** Our practice policies are subject to change from time to time and all patients are responsible for abiding by our practices policies in effect during the duration of their care and affiliation with our practice. You may visit our website to review and download a current copy of our practice policies at any time.

Patient Information and Other Paperwork: **We cannot bill your insurance company without a fully completed Patient Information form, signed and dated, and a copy of your current insurance card(s).** We completely understand that you have given the same information to other providers, but you must give us complete information or we will be unable to bill your insurance and you will be required to pay for your office, DME and/or surgery charges in full. We also require you to read and sign the Health Insurance Portability and Accountability Act (HIPAA) policy of our office.

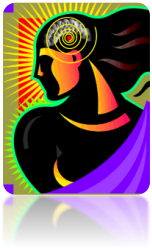
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Insurance and Billing Policies: Although ENC providers participate with most of the managed care health plans in this area, it is your responsibility to confirm with your particular insurance carrier whether we are participating or non-participating. Whether we participate with your plan or not, it is important for you to understand that, while we accept the contract terms we have with many plans, timely payment for your care is ultimately your responsibility. Payment is due in full at the time of your visit. **Just as we have a contract with your insurance plan to abide by certain terms and conditions, your policy also requires that you abide by certain terms and conditions.**

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Copayments and coinsurance. A copayment is the stated patient share for an office visit, usually noted on your insurance card, and is due on the date of service. If you cannot pay your copayment on the date of your visit, we will be happy to reschedule you to our next available appointment time. Please see our Payment Policies for our policies on payment of deductibles, co-insurance, and patient responsibility of surgical procedures.

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Referrals and authorizations. We are a referral-based practice and require that you have been referred by a primary care physician or other health provider who has evaluated your problem and has recommended a consultation by neurosurgery. This is true whether or not your insurance plan requires an actual authorization for you to be seen by our neurosurgeons. If your insurance plan requires an authorization for your office visit to this practice, **it is your responsibility to obtain that authorization prior to your visit and it is your responsibility to be sure that we have received that authorization prior to your visit.** Please feel free to call us prior to your appointment to check on the status of any authorization. In some situations, it may be necessary for us to have a written authorization before we can schedule an appointment for you.

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Authorizations for treatment, diagnostic testing, surgery, durable medical equipment and information pertinent to my ongoing care. I grant ENC the authority to download my medication history automatically from pharmacy benefit managers (PBMs) for the purpose of treatment and coordinating my care. When we recommend and order further diagnostic testing, prescriptions, treatment with another provider, surgery, or durable medical equipment (such as bracing), it will be up to you to obtain verification of coverage. Please have your insurance plan contact us for any necessary authorization. It may take several days or even longer for us to obtain these authorizations. Please be patient and feel free to contact us for an update through the patient portal.

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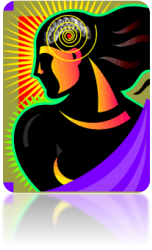
THIS SECTION INCLUDES IMPORTANT INFORMATION REGARDING WHAT YOU CAN EXPECT – PLEASE CONSULT THIS FREQUENTLY PRIOR TO CONTACTING ENC

Medical Care Policies: **If, after consultation with one of our neurosurgeons, you decide to continue with treatment, it is important that you understand and agree to follow the recommendations made to you.** If you are non-compliant with recommendations and treatment, we will be unable to best serve your healthcare needs and you may be asked to leave the practice. We participate in a patient-centric healthcare model and work closely with other providers on your healthcare team in order to optimize your care. Please feel free to ask questions regarding any treatment recommendations and please bring a significant other to help you better understand and remember recommendations discussed.

Initial: _____

Pain Management. The MD/PA will treat your acute pain while you are an active patient in our practice. We provide acute pain management prior to and for a short period after your surgery (usually no more than 3 months). Narcotic medications are strictly monitored and will not be refilled prior to the refill due date. If you lose your narcotics for any reason, we will not provide an additional refill. It is your responsibility to keep close track of your own medications. If you lose your narcotics or use them outside of the instructions, we will no longer provide your pain management.

- Because narcotics interact with other medications, long term use will need to be monitored through a chronic



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pain management doctor or your primary care doctor.

- No narcotics will be called in on a weekend or at night. If you are running out, allow 48 hours to process a refill. Many narcotics cannot be refilled via fax or telephone; in that case you will be responsible for picking up the prescription in our office during regular business hours.

Initial: _____

Prescription Refills. ENC providers will only refill medications that have been prescribed by a MD/PA within our practice. All refills must be requested via fax from your pharmacy. **Our fax number is 720-638-0497.** Refills are processed within 48 hours of receipt from your pharmacy. No refills will be processed at night or on weekends.

Initial: _____

Phone Calls. At ENC, our goal is provide you with the best possible medical care. In the event of a medical emergency, call 911 or go directly to the Emergency Department. **All inquiries (medical questions, concerns, appointment or billing requests, etc.) should go through our patient portal for efficient HIPAA compliant communication.** Please understand that our doctors and physician assistants are usually either at the hospital seeing patients, performing surgery, or are seeing patients in clinic. Therefore, please allow up to 48 hours for return of all non-emergent phone calls and portal communication and do not leave multiple messages. **Our policy is to treat you with respect and consideration, and we expect the same consideration in return.**

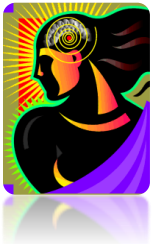
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Test Results. When we schedule you for radiological studies (MRI, CT scan, etc.) or for conservative therapies such as physical therapy or pain injections, we will schedule a follow-up appointment in the office for you to discuss the results with the doctor. Generally, unless there is a problem seen on the studies or your condition becomes worse, we do not discuss these results with you on the phone, and you should wait until your scheduled appointment for the results.

Initial: _____

Medical Records and Insurance Forms.

1. To obtain copies of your medical records or test results, please fill out the **HIPAA Authorization for Release of Medical Information** form from our website and fax to ENC at **720-638-0497**. We only provide copies of medical records that are generated by our office. Please allow up to 4 weeks for copies of medical records. **Fees charged are defined under Colorado law C.R.S. 25-1-801.**
2. We will complete forms for short-term disability postoperatively. The first set of forms will be completed at no charge. There will be a charge of \$25 for completion of each additional set of forms after the first. Please allow 30 days for completion of forms.
 - Filling out any form or letter is always at the discretion of the provider.
 - Patients may NOT tell the provider how to fill out the form or what to write.



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- Forms given by lawyers or advocacy groups for disability are not required for the disability application and will not be filled out. (These often include items such as how far a patient can walk, how long they can hold five pounds, how long they can sit or stand, etc.)
- Patients who argue with their providers or repeatedly call to get forms filled out will be at risk of being asked to leave the practice.

3. We **DO NOT** complete or process long-term (anything longer than twelve weeks) disability forms.

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Rescheduling and Delayed Appointments.

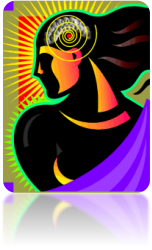
1. Last-minute rescheduling. The providers at ENC are also responsible for Emergency Trauma Call and Neurosurgical Emergencies at the hospital and may be called to the hospital during office hours. While this occurs infrequently, we will need to reschedule your office appointment and sometimes even your scheduled surgery. We understand that this creates an inconvenience for you, but appreciate your patience for these unpredictable interruptions to our schedule.
2. Occasional delays in being seen at your scheduled appointment time. Because of the nature of neurosurgical conditions, there are some times that we have a patient in the office with a particularly difficult problem that we could not possibly have predicted when appointments were made. We apologize for the inconvenience this causes you, but we assure you that you will receive the same courtesy when you are with the doctor.

Initial: _____

No Show Policy. Failure to keep scheduled appointments is costly to both the clinic and you as a patient. We require at least 48-hour notice through the portal if you are unable to keep your scheduled appointment. If an urgent situation will prevent you keeping your appointment, please notify us as soon as possible and at least 48 hours before your appointment is scheduled through our portal. When you fail to notify us of your inability to keep an appointment, we are unable to accommodate other urgent patients who may need to be seen. We will reschedule you to our next available appointment time and will not be able to fit you into our schedule “urgently” unless a cancellation is available. If you have not notified us at least 48 hours prior to your appointment of your cancellation through the portal, you will be billed for a “no show” office visit appointment. You are still responsible for payment of all missed or “no show” appointments and most insurance companies will not reimburse you. Patients who regularly fail to keep their appointments or have missed 2 consecutive appointments will be considered dismissed from the practice, and a letter of dismissal will follow.

Initial: _____

Minor Patients. Per Colorado statutes, all persons under age 21 (not age 18) are considered minors and are required to have a parent or legal guardian present with them for each appointment to provide consent for treatment, as required by law. Minors are also not allowed, by law, to sign as financially responsible. If a parent or legal guardian cannot be present for the appointment, we will be happy to reschedule the appointment to our next available time when the parent or



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guardian can be present.

Initial: _____

Release of Medical Information. By allowing a family member or other person to be present during your appointment with the doctor or physician’s assistant, you are giving your implied consent for us to discuss your medical information in their presence. If you would like to give permission or deny permission for us to release your medical information to any family member or other person by any other means when not in your presence, please be sure to indicate your instructions on the signature page of the HIPAA policy form you have been given to sign.

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Patient Portal. In order to facilitate ongoing HIPAA compliant communication with Epstein Neurosurgery Center, LLC, I agree to enroll in and only use the AthenaHealth HIPAA compliant patient portal used by Epstein Neurosurgery Center, LLC for ongoing communication with ENC. I acknowledge that I can enroll at <http://epsteincenter.com/patient-resources> and agree to enroll prior to my first appointment if I have not already done so. AthenaHealth patient portal terms and conditions, privacy practice and website privacy policies can be reviewed at <https://5983.portal.athenahealth.com/> **All inquiries and communication (medical questions, concerns, appointment or billing requests, appointment cancellations, etc.) should ONLY go through our patient portal for efficient HIPAA compliant communication. ENC will not acknowledge other forms of communication such as texts, email, etc. which will be deleted.**

Initial: _____

I have read and understood this entire document and consent to evaluation and treatment to be provided by Epstein Neurosurgery Center, LLC. I will be in compliance with the above practice policies.

Print Patient’s Name _____ Date _____

Patient or Guardian’s Signature _____