Kane Hall Barry NEUROLOGY

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PATIENT CENTERED QUALITY CARE SINCE 1995

Welcome to KANE HALL BARRY NEUROLOGY

We value your confidence in our ability to address your specialized healthcare needs. Kane Hall Barry Neurology, where your health and well-being are our top priorities, offers comprehensive neurological healthcare services including expert clinical diagnostics, specialized neurological testing, and up-to-date treatment of diverse disorders affecting the brain, spinal cord, peripheral nerves, and muscles.

At Kane Hall Barry, we are dedicated to providing exceptional neurological care with compassion and empathy. Our practice is committed to fostering a warm and welcoming environment, ensuring your comfort from the moment you step through our doors. Our team consists of highly skilled and compassionate professionals who are devoted to delivering the highest quality of care. Your trust in us is paramount, and we are here to address your concerns, answer your questions, and guide you towards a healthier and happier life.

Included in this package is the essential information required to establish a meaningful partnership between us. This comprehensive packet has been crafted to guide you in optimizing the advantages derived from the services we provide.

Welcome Packet:

- Office Policy
- Financial Policy
- Release of Medical Records form
- HIPAA Restrictions and Permission Form

Compliance with this policy is mandatory to receive medical services at our facility. We look forward to being of service to you.

Thank you for choosing Kane Hall Barry Neurology.

---------- SECTION 1. OFFICE POLICY ---------

1. **Patient Identification:** To enhance identity protection in compliance with the Federal Trade Commission's "Red Flag" rule, which mandates healthcare providers to establish anti-identity theft programs, our office has implemented a patient identification policy**.** Our Office will require a valid photo identification from all patients upon check-in. This also ensures that we can correctly match patient information with their medical records, safeguarding their privacy and enhancing the quality of care provided. If, at the time of your visit, you are unable to provide proper identification, we regret to inform you that we will need to reschedule your appointment.
2. **Minors:** It is mandatory for the parent(s) or guardian(s) to be present during the visit, and they are responsible for the full payment of services, as well as the receipt of billing statements.
3. **Assignment of Benefits and Authorization to Release Medical Information:** I hereby certify that the insurance information I have provided is accurate, complete, and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.
4. **Consent to Treatment:** I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time. My consent shall cover medical examinations and diagnostic testing, including, but not limited to, minor surgical procedures (injections) and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.
5. **Prescription Refills**: Patients must contact their pharmacies directly to request any prescription refills for medications that our provider prescribes. In turn, the individual pharmacies will contact our organization with those requests. Please allow 5 business days for medications to be filled. Refills requiring a prior authorization take a minimum of 10 days.

6. **Consent to Call, Email & Text:** I understand and agree that my provider may contact me using automated calls, emails, and/or text messaging sent to my landline and/or mobile device. These communications may notify me of appointments, reminders, preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt out of receiving all such communications from my provider by notifying my provider's staff or by visiting "My Profile" on my Patient Portal.
7. **Marketing Communication:** I acknowledge and consent to receive marketing text/emails including information regarding goods/services/events/promotions etc. that we believe may be of interest to you. You may opt out of these messages at any time. Your care will not be affected if you choose to opt out of marketing communications; you will continue to receive healthcare related messages.
8. **Privacy Notice:** I understand that my provider's Privacy Notice is available on my provider's website at kanehallbarry.com and that I may request a paper copy at my provider's reception desk.
9. **HIE**: At Kane Hall Barry Neurology, we prioritize the seamless sharing of health information to enhance the quality of your care. To ensure comprehensive coordination, we have adopted a Health Information Exchange (HIE) policy with opt-in by default. This means that, by default, your health information will be shared among our trusted network of healthcare providers for a more integrated and informed approach to your well-being. If, however, you prefer to opt out of this system, you can easily make that request through our secure patient portal or by contacting us directly via phone. Your privacy and preferences are important to us, and we are committed to accommodating your choices regarding the sharing of your health information.
10. **No Guns Policy:** For the safety and well-being of all individuals on our premises, we strictly prohibit the presence of firearms or weapons of any kind by patients. We appreciate your cooperation in maintaining a secure and peaceful environment within our facility.
11. **No Photo or Recording Policy:** To uphold the privacy and confidentiality of our patients and maintain a secure environment, we kindly request that no photo or video recording be conducted on the premises. We appreciate your understanding and cooperation in respecting the privacy of individuals seeking care within our facility.

---------- SECTION 2. FINANCIAL POLICY ---------

We do not accept any cash or checks. We offer contactless payment options through the online portal, self-check-in, and in-office. We accept all major cards: Visa, MasterCard, American Express, Discover Card, and CareCredit.

PAYMENT IS DUE AT THE TIME OF SERVICE

1. **Guarantee of Payment & Pre-Certification:** In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses, and attorney's fees incurred by my provider to collect those charges. If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in a reduction or denial of benefit payments and that I will be responsible for all balances due.
2. **Pre-Authorizations/Referrals**: While we will do our best to obtain required authorizations and referrals, it is the responsibility of patients to ascertain whether a referral is required for office visits. Opting not to adhere to payer policies on obtaining a referral from a Primary Care Provider may result in the patient being categorized as Self-Pay, with full payment required at the time of service. Failure to comply may require rescheduling and may incur a fee. Patients are also accountable for verifying with their insurance carrier whether recommended testing is covered under their medical coverage policy. If a patient opts for non-covered testing, full payment will be required at the time of service.
3. **Cost Estimates:** We are committed to understanding your benefits and providing you with a cost estimate for your care before your appointment. Estimates are just that – estimates. Things can, and do, sometimes turn out differently. While we do our best to provide cost estimates as a courtesy, please inform us of any changes to your information such as name, address, phone numbers, and/or insurance information before your appointment. If you have any questions, please call us before your appointment so there are no surprises when you check-in. You are aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You may be asked to pay for these services in full at the time of the visit and/or be responsible for any amounts uncovered by the insurance payor.
4. **Self-Pay:** If you are uninsured, you will be responsible for payment in full at the time of service. Upon request, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, healthcare providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.
5. **Credit Card on File:** We kindly request that all patients provide a valid credit card to be securely stored on file. This credit card on file will be utilized for settling any outstanding balances or charges not covered by insurance. This streamlined approach ensures an efficient payment process, allowing you to concentrate on your health. Rest assured, we will provide a 5-day advance notice before auto-processing the card, offering transparency, and allowing you ample time to address any concerns.

6. **Financial Assistance:** Kane Hall Barry Neurology offers payment plans at any given point. If our payment plans do not meet your needs, we suggest contacting CareCredit before your visit for financing options. They can approve your application before your appointment, typically within minutes of submitting your information, allowing you to pay for your visit over time. To learn more, visit www.carecredit.com or call 1-800-677-0718.
7. **Non-covered insurances:** Kane Hall Barry Neurology does not accept Motor Vehicle Accident Cases, Worker's Compensation cases, letters of protection, or any 3rd party liability coverage. Also, we do not accept any new patients with Medicaid insurance (primary or secondary).
8. **Medical Appointment Cancellation and No-show Fees:** When you schedule an appointment with Kane Hall Barry Neurology, we set aside enough time to provide you with the highest quality of care. We understand that sometimes you may need to cancel an appointment due to unforeseen circumstances just as we sometimes need to reschedule your appointment. Missed Appointments/Late Cancellations: Notice of 1 full business day allows us to offer that time to other patients who are waiting to be seen. Therefore, if you miss an appointment, or if you cancel or reschedule an appointment with less than 1 business day's notice, we may charge a late cancellation fee of $25 for office visit appointments and $75 for all other appointments. You may be discharged from the practice for multiple instances of no-shows/cancellations. Late Arrival: If you find yourself running behind schedule, kindly inform us promptly so that we can collaborate with you to determine the most effective way to deliver your care. Please be advised that arriving more than 15 minutes past your scheduled appointment time will be marked as late arrival and fees will incur. While we will make every effort to accommodate you, we cannot guarantee it. Your understanding and cooperation are appreciated.
9. **Interpreter and Translation Services.** If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least forty-eight (48) hours before your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.
10. **Returned Checks**: The office will assess a $50 return check fee for insufficient funds.
11. **Paperwork Requests:** Please refer to our website for the most up-to-date information regarding records requests. Fees may apply.

ACKNOWLEDGEMENT FORM

By signing below, you:

1. Agree to all sections (1&2) outlined in these pages of Patient Policy Rev. 012024.
2. Agree to receive electronic documents accessible via our patient portal or website. A paper copy is available upon request.
    a. Kane Hall Barry Neurology Notice of Privacy Practices
    b. Kane Hall Barry Neurology Patient Policy
        i. Kane Hall Barry's Financial Policy
        ii. Kane Hall Barry's General Office Policy
3. Agree that this form applies and extends to subsequent visits and appointments with any Kane Hall Barry Neurology location and/ or providers.
4. Have carefully read and agree to the terms above and understand that any failure to comply with any of these terms may result in discharge from Kane Hall Barry Neurology.

X_____ PATIENT SIGNATURE	_____ PRINT PATIENT NAME & DOB	_____ TODAY'S DATE
To be signed by the patient's parent or legal guardian if the patient is a minor or otherwise do not complete.		
X_____ LEGAL GUARDIAN SIGNATURE	_____ LEGAL GUARDIAN NAME	_____ RELATIONSHIP