

Imaging Center at CDA Spine

Date: _____ Legal Name: _____ Ht: _____ Wt: _____ M / F

Referring MD: _____ SSN: _____ Date of Birth: _____

Previous Related MRI: Y/N If yes, when? _____ Where: _____

What symptoms are you experiencing? _____

Is this a result of an injury: Y/N If yes, When? _____

If yes, please explain: _____

**WARNING: PLEASE ANSWER THE FOLLOWING QUESTIONS APPROPRIATELY
- Some items could be a contradiction for an MRI and may be life threatening.**

Y N Heart surgery/Heart valve/Pacemaker/Defibrillator/Stent

Y N Brain aneurysm clip/Shunt/Stent/Coil

Y N Metal in eye

Y N Prosthesis (eye / penile)

Y N ANY Implants/Pumps/Stimulators If yes, type: _____

Y N ANY kind of cancer Type: _____ When: _____

Y N Back surgery Type: _____ When: _____

Y N Neck Surgery Type: _____ When: _____

Y N Prior surgeries on body part being scanned

Y N Hearing Aid/cochlear implant

Y N Pregnant/Nursing

Y N ANY type of medication patch on your person

Y N Tattoos/Permanent makeup

Y N Metal Dentures

Y N ANY other metal in your body for ANY reason If yes, type: _____

I have answered these questions to the best of my ability. I acknowledge that I have had the opportunity to ask questions related to this form and the MRI procedure and I fully understand the information presented to me.

Signature: _____ Date: _____ Witness Initials: _____

Insurance Information: Please read the following sections carefully.

Medicare Patient Only:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coeur d'Alene Spine and Brain, PLLC for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

Primary Insurance Company: _____ **Phone:** _____

Name of the Primary on Insurance: _____ Soc. Sec. Number: _____

Date of Birth for Primary on Insurance: _____ Relationship to Patient: _____

Insurance Address: _____

Policy #: _____ **Group #:** _____

Does your insurance require pre-authorization for visits to a doctor? [] Yes [] No

Secondary Insurance Company: _____ **Phone:** _____

Name of Insured: _____ Soc. Sec. Number: _____

Insurance Address: _____

Policy #: _____ **Group #:** _____

Does your insurance require pre-authorization for visits to a doctor? [] Yes [] No

Worker's Compensation Information:

Carrier: _____ Claim #: _____

Claim Office Address: _____

Adjuster: _____ Phone: _____

Date of Injury: _____ Employer: _____

Are you represented by an attorney? [] Yes [] No

Name of attorney: _____ Phone: _____

I authorize Coeur d'Alene Spine and Brain, PLLC to appeal claims on my behalf when deemed necessary.

Signature: _____ Date: _____

Coeur d'Alene Spine and Brain, PLLC

Policies Acknowledgement Form

Please read the following information regarding your care and patient responsibility at Coeur d'Alene Spine and Brain. You will be asked to sign on the second page indicating you have read and understand the policies, procedures and your financial responsibility as a patient.

Patient Name: _____

DOB: _____

Patient Financial Responsibility

Coeur d'Alene Spine and Brain appreciates the confidence you have shown in choosing us to provide for your health care needs. The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Coeur d'Alene Spine and Brain, PLLC is contracted with the following: **Medicare, Medicaid of Idaho, Blue Cross of Idaho, Regence Blue Shield of Idaho (We are NOT contracted with Regence Med Advantage Plans), First Choice Health Network, Group Health (Dr. Michael Ludwig and Imaging Services ONLY), WA L&I (Imaging Services ONLY).**

*****IF YOUR INSURANCE IS NOT INCLUDED ON THE LIST ABOVE YOUR SERVICES WILL MOST LIKELY APPLY TO YOUR OUT OF NETWORK BENEFITS. IT IS STRONGLY RECOMMENDED THAT YOU CONTACT YOUR INSURANCE TO VERIFY YOUR COVERAGE AND BENEFITS PRIOR TO YOUR VISIT. *****

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Prescription Refill Policy

Coeur d'Alene Spine and Brain providers will not fill prescriptions after set hours or on weekends. Post-surgical patients will receive prescriptions for a set period of time depending on their surgery and their adherence to the prescription directions. After this time period it is the patient's responsibility to make any necessary arrangements with their primary care physician for any further refills. NOTE: New law mandates that narcotic medications will only be filled with a written prescription. We are no longer able to call in these types of prescriptions. Prescriptions will need to be picked up in the office by the patient, unless the patient has notified the office in writing of their request to allow another individual to pick up the prescription. In those instances, the authorized individual will need to bring in their ID in order to pick up the prescription. Patient's picking up their own prescription will also need to bring a valid photo ID in order to pick up the prescription. It is your responsibility as a patient to manage when you will need a refill and notify the office in a timely fashion. Refills for non-narcotic medications should be phoned into the pharmacy to request any needed refills. Prescription refills will only be filled in accordance with the office policy (which is posted and may be subject to change). Please take time at each office visit to ensure that you are current on any prescription policy changes (both state mandated and internal).

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Cancellation/ No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to cancelling your appointment. Patient's who "no show" without advance warning for two consecutive appointments may be discharged from care. Coeur d'Alene Spine and Brain will notify you in writing, via certified mail, if you are discharged from care.

Self-Pay

Patient's that do not have health insurance will be responsible for payment of services rendered here at Coeur d'Alene Spine and Brain. The patient will be responsible to pay Coeur d'Alene Spine and Brain the full and entire amount of treatment given to them or to the above named patient at each visit.

Patient Initials: _____

Date: _____

Coeur d'Alene Spine and Brain, PLLC

Policies Acknowledgement Form

Motor Vehicle Insurance (PIP)

Patient's wishing to file claims through a motor vehicle carrier, are responsible for ANY bills incurred that are not covered and/or paid for using the PIP benefit through the motor vehicle insurance.

Self Referral Notice (Imaging Services)

Pursuant to Section 6003 of the Patient Protection and Affordable Care Act (PPACA), with respect to referral for magnetic resonance imaging (MRI), the referring physician must inform a patient in writing at the time of the referral that a patient may obtain the service from a person other than the referring physician or someone in the physician's group practice. Coeur d'Alene Spine and Brain is pleased to be able to provide you with convenient and timely scheduling of your MRI. Having the capability of an ACR accredited MRI in-house has allowed our physicians to treat patient's more quickly, conveniently and competently at a competitive price. We take pride in delivering high quality services. There are other medical facilities in our immediate area that provide similar services. Kootenai MRI 2003 Kootenai Health Way, Coeur d'Alene ID 83814 (208) 666-2190 (Joint venture with KMC) ; Kootenai Outpatient Imaging 700 Ironwood Dr. Ste. 110, Coeur d'Alene ID 83814 (208) 666-3200 (Joint venture with KMC) ; Kootenai Outpatient Imaging-Post Falls 1300 E Mullan Ave. Ste. 700, Post Falls ID 83854 (208) 777-1305 (Joint venture with KMC), Northwest Specialty Hospital 750 N Syringa, Post Falls ID 83854 (208) 262-2390. If you would like to receive services at another facility, please notify our staff and they will be happy to provide you with a referral.

Self Referral Notice (Pleasant View Surgical Center)

Pursuant to Section 6002 of the Patient Protection and Affordable Care Act (PPACA), with respect to transparency reports and reporting of physician ownership or investment interests, CDA Spine and Brain would like you to be aware that Pleasant View Surgery Center is owned in part by physicians. Jeffrey Larson, M.D. and Michael Ludwig, M.D. are part owners in the surgery center. CDA Spine and Brain providers may choose to refer you to have your surgery/procedure done at Pleasant View Surgical Center and may also be performing your surgery or other services in connection with your referral. Please discuss this matter with your physician so that you may exercise your right to be treated in another health care facility if desired. Upon your request, your physician will provide names and addresses of alternative facilities where you may go to obtain services.

Consent for Treatment and Authorization to Release Information

I am aware that by signing below, I authorize Coeur d'Alene Spine and Brain, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I also authorize Coeur d'Alene Spine and Brain, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

To help protect our patient's privacy, Coeur d'Alene Spine and Brain requires patient's to sign a medical records release prior to releasing any records. We understand that there are situations where another medical provider might need pertinent information in order to expedite your medical care. To help you receive timely care, Coeur d'Alene Spine and Brain will release medical information via verbal and written requests from other physician's offices without a signed release.

By signing below, I am aware that Coeur d'Alene Spine and Brain will do their best to protect my confidential information, but I understand that it is possible for someone to misrepresent themselves by telephone and/or forgery and that my right to privacy may be compromised.

Notice of Privacy Practices (HIPAA)

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Lisa R. Tansy, Administrator. Our Notice of Privacy Practices (HIPAA) describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like a copy for your records you may request one from the front desk or you may download a copy on our website www.cdaspine.com.

I hereby authorize that I have read the Coeur d'Alene Spine and Brain Policies Acknowledgement Form in its entirety (2 pages) and understand my responsibilities and options as a patient.

Patient Signature: _____

Date: _____

Guarantor Signature : _____

Date: _____

(if guarantor is not the patient)

Today's Date: _____
 ID Number: _____
 Patient: _____
 Claim #: _____
 Provider: _____
 Date of Serv: _____

Incident Report

Please complete this Incident Report and return it in the enclosed envelope within 45 days of receipt. If we do not receive your complete and signed Incident Report within forty-five days, all claims related to this incident will be denied until the Incident Report is received. Please be aware that if claims are denied due to tardiness in returning your completed Incident Report, charges billed by your provider will be considered your responsibility and the provider may bill you directly for these expenses.

Complete information is essential and very much appreciated. When additional information is required, claims cannot be processed. It will take up to 15 days after we receive all necessary information before claims can be processed. To avoid delays, carefully and completely provide all requested information.

GENERAL INFORMATION

Briefly explain why you sought treatment. Please identify the specific body area(s) affected by this injury, if applicable. How did the injury occur? What was injured? Where did the event occur?

Date of injury or onset of illness _____ Explanation _____

Was the service received for the injury described above related to an incident that occurred:

- At work or on the job; or
- Due to an auto accident or auto-related injury; or
- Due to an Other Vehicle Accident (motorcycle, scooter, snowmobile, boat, etc. accident); or
- Caused by another party; or
- Caused by something/someone at a business or residence other than your own home?

The service received from the injury described above:

- Was not incurred at work or on the job; or
- Was not caused by another party or incurred as the result of an accident; or
- No other person was involved. Please explain above.

If the injuries you sustained were not related to an accident or incurred at work or on the job, please skip to the end of this form and sign, date and return it to us.

Otherwise, please continue on and complete the applicable section(s) on pages 2 and 3, then sign, date and return the form.

GENERAL INFORMATION (continued)

Do you intend to seek recovery for damages from the party responsible for the accident, injury or work-related condition? Yes No

Have you been offered a settlement? Yes No

Have you accepted a settlement? Yes No

If Yes, date of settlement _____ Amount of settlement _____

Please include a copy of your settlement documents

Have you hired an attorney? Yes No

Attorney's Name _____ Phone Number _____

Attorney's Address _____

Was the treatment a result of an auto/other type of vehicle injury/accident?

Yes (please give details below) No

The patient was a: Driver Passenger Pedestrian Other

The vehicle was a: Car Motorcycle ATV Snowmobile Other

Were there more than two vehicles involved? Yes No

Name of the At-Fault Party _____

At-Fault Party's Insurance Company _____

At-Fault Party's Insurance Company's Address _____

Adjuster's Name _____ Adjuster's Phone Number _____

Claim Number _____ Adjuster's E-mail Address _____

Do you have vehicle insurance? Yes No *If No, attach a copy of police report.

Is there Personal Injury Protection (PIP) or Medical Payments (Med-Pay) under your vehicle insurance?

Yes No Please attach a photocopy of your insurance policy declaration page that shows what types of coverage you have (in particular, whether your policy provides PIP or Med-Pay coverage) and the monetary amount of your coverage.

Name of your Insurance Company _____

Insurance Company's Address _____

Adjuster's Name _____ Adjuster's Phone Number _____

Claim Number _____ Adjuster's E-mail Address _____

Name of other family member(s) covered on your health plan that were injured _____

GENERAL INFORMATION (continued)

If accident was not in your own vehicle, name and address of owner of vehicle in which patient was traveling.

Insurance Company, Claim Number, Adjuster's Name and Phone Number for vehicle in which patient was traveling.

Did this vehicle policy have PIP or Med-Pay benefits for passengers? Yes No

***If PIP/Med-Pay is exhausted, please provide copy of auto insurance payment ledger.**

WORK-RELATED CONDITION

Was the service you received necessitated by an injury, condition, or illness caused or received at work or on the job? Yes No

If Yes, please tell us what happened _____

When (or over what period of time) did you incur your injury or illness _____

Have you filed a claim with Workers' Compensation? Yes No

If Yes, please provide: Claim Number _____

Workers' Compensation Carrier Name, Address _____

Adjuster's Name _____ Adjuster's Phone Number _____

***If your claim was denied or closed, please attach a copy of your closure notice or denial.**

Do you plan to appeal this decision? Yes No

Are you self-employed? Yes No

If Yes, do you carry an industrial policy for yourself? Yes No

Name and Address of Industrial carrier (if applicable) _____

OTHER ACCIDENT OR INJURY

Did the accident or injury occur on someone else's property? Yes No

Do the property owners have insurance to cover medical expenses? Yes No

Do you intend to file a claim? Yes No

If Yes, please provide the name of the insurance company _____

Adjuster's Name _____ Claim Number _____

Address _____ Phone Number _____

SUBSCRIBER STATEMENTS

I understand that if I, or any of my covered dependents ("Subscriber") have been in an accident or have been injured by another party, or have work-related condition, the benefits of my health benefit plan will be available to me or my covered dependents, subject to the terms, limitations, and exclusions of the plan. The Subscriber further understands that as a condition of coverage, the health benefit plan requires the Subscriber to cooperate with the insurance carrier in its efforts to recover the cost of benefits it has provided from the responsible party or the responsible party's Insurer, and that if the Subscriber does not cooperate in full accordance with the health benefit plan, that the insurance carrier may pursue reimbursement from the responsible party, or the responsible party's insurer, or from the Subscriber in accordance with the health benefit plan and applicable law.

The Subscriber understands that the insurer and anyone acting on its behalf is permitted by law to release information about any accident, injury, or work-related condition described on the Incident Report and the benefits and medical service the Subscriber received in connection with that accident, injury or work-related condition to any potentially responsible party and the potentially responsible parties' insurer.

The Subscriber authorized the insurance company(ies) listed on pages 2 and 3 to release any information concerning the Subscribers coverage to the insurer. The Subscriber further authorizes to review the Subscriber's workers' compensation claims files pertaining to this Incident Report so that the insurer can determine whether workers' compensation coverage is available for any potential work-related condition.

The Subscriber understands that it is a crime to knowingly provide false, misleading, or incomplete information to the insurer with the intent of defrauding the company, and that the penalties for committing fraud include imprisonment, fines and denial of insurance benefits. Moreover, the insurer will have the right to pursue its legal rights, including the collection of claims payments and any other damages.

The Subscriber accordingly declares that the information on pages 1 through 3 is true, correct and complete.

DATE and SIGNED on the _____ day of _____, 20_____.

Home Phone Number _____ Work Phone Number _____

Cell Phone Number _____ Email Address _____

SUBSCRIBER SIGNATURE: _____

Date _____ Insurance ID Number _____

Injured Dependent/Guardian Signature _____

Date _____ Relationship _____

We (the insurer) may need to contact you further to clarify your answers or obtain additional information. Please include available times if there are time restrictions regarding when you should be contacted.

Additional information/clarification _____

