



LUBBOCK
SPINE
INSTITUTE

COMPREHENSIVE SPINE TREATMENT

Welcome to Lubbock Spine Institute

Thank you for entrusting us with your healthcare needs.

Enclosed you will find patient information forms that need to be completed.

If you have any questions, please do not hesitate to contact our office.



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HIPAA (Health Information Portability & Accountability Act)

I understand that at any time I may contact LSI to obtain a current copy of the Notice of Privacy Practices as it pertains to my treatment with LSI & its physicians & midlevels.

1) I authorize my doctor and his clinic staff to release my private medical information to: (Example: Family members, attorney, friends, or social security administration.)

Name	Relationship
_____	_____
_____	_____
_____	_____

2) I authorize my doctor and his clinic staff & third party entities contracted with NSA to leave messages with myself or others on recording devices at the following numbers:

YOUR Primary Phone Number: _____

YOUR Secondary Phone Number: _____

I authorize my doctor and his clinic staff to release my private medical information to all medical sources involved in my care, including insurance health plans, physicians, health care professionals, hospitals, clinics, laboratories, pharmacies, medical facilities, third party entities contracted with LSI or other healthcare providers that have provided payment, treatment or services to me or on my behalf.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the healthcare operations of LSI. LSI is required to agree to any restrictions that I may request. If, however, LSI agrees to any restriction requested by me, such restriction shall be binding on LSI and it's physicians and midlevels. I further understand that I have the right to revoke this consent, in writing, at any time, except to the extent that LSI and it's physicians and midlevels has taken action in reliance on this consent.

- I consent to the terms of this agreement.
- I do not consent to the terms of this agreement.

Signature: _____

Date: _____

Printed Name: _____

Witness: _____

Patient Financial Contract

I, _____ (Patient's Name) agree to the terms of this financial contract. I agree that if I do not meet the payment guidelines LSI can refer me with or without notice to the collection bureau of his choice. By signing below I am acknowledging receipt of this document and therefore giving my permission to send my account to collections if I do not adhere to the payment guidelines.

Payment guidelines are as follows:

1. I will be responsible for any and all balances left to patient responsibility by my insurance company.
2. I will be responsible for any patient balances due to deductible, co-insurance, co-pay, termed insurance or non-covered services.
3. I will agree to pay 10% of the entire balance or \$100 a month, whichever is greater.
4. I agree that my account may be sent to collections if I do not make a monthly payment when owed.
5. This applies to any and all balances incurred with LSI, LLP.

This is a financial contract between LSI and the patient. By violating this agreement the patient agrees to be sent to collections and can be dismissed from LSI.

Assignment of Benefits

I hereby give lifetime authorization for payment of insurance benefits to be made directly to LSI and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of a default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I agree to pay 10% or \$100 per month whichever is greater.

Patient Name: _____

Patient Signature: _____ Date: _____