Atlantic Neurosurgical & Spine Specialists, PA
(910) 763-3333 ● fax (910) 763-3336

Dear, _____

You're scheduled for an appointment on _____, please **ARRIVE** at _____, for your schedule appointment time of, _____, you appointment will be in the location of:

☐ 2208 South 17th Street Wilmington NC 28401 ☐ 215 Station Street Jacksonville NC 28546

Provider: ☐ Dr. Huffmon ☐ J. Probst, PA-C ☐ Dr. Thomas ☐ J. Bagley, PA-C ☐ Dr. Beecher ☐ J. Ward, PA-C

What to bring on your first visit?

1. All medications or a complete prescription list.
2. All films or CD with your films on it that have been performed within the last 3 years. If we do not have your films, your appointment will need to be rescheduled.
3. Insurance Cards
4. All paper work that was sent to you should be filled out **prior to your appointment time**.

Office Policies & Procedures

- **NEW PATIENTS:** Bring all films and/or CD's related to your condition, paperwork mailed from our office, a list of medications or the bottles, a photo ID and a valid insurance card. **CD's of radiology images and an updated medication list will be required for every appointment.**
- **CANCELLATIONS:** must be made 24 hours prior to your appointment. **We charge $25.00 for appointments not cancelled or rescheduled 24 hours in advance.** If you are more than 15 minutes late to your appointment, you will be asked to reschedule. This fee will need to be paid prior to being seen again in our office.
- **MIDLEVEL PROVIDERS:** We have Physician Assistants who are utilized in our office to both evaluate and treat patients. They are well trained and competent in their evaluation process, available to answer questions, and will be a part of your plan of care.
- **INSURANCE:** Currently, we participate with Blue Cross/Blue Shield, United Healthcare, Aetna, Medicare, Medicaid, Workman's Compensation and Vocational Rehabilitation. **We do not file liability claims.** If you have an attorney, you will still be required to pay for your visits in full at the time of service. Although we are out of network for other insurance companies, it may be possible for you to obtain in-network or GAP authorization by contacting your insurance company and making the request due to a limited number of neurosurgeons in this area. It is your responsibility (or referring physician office) to contact your insurance company about authorization prior to your initial visit. After the initial visit, we are usually able to call if additional visits are needed. If you have questions, please do not hesitate to contact our billing department at (910)763-3333.
- **PAYMENT:** Co-pays are collected at check- in prior to services being rendered. If you do not have your co-pay, your appointment will be rescheduled. Payment is due from each patient at the time of service which includes deductibles, percentages of patient responsibility, and co-pays. Our office will bill your insurance company for all services we provide at the office and hospital, but the hospital and other treating physicians will send a separate bill for their services. There will be a $30.00 service fee on all returned checks. Past due balances and fees must be paid prior to being seen for a return appointment. If a minor is being treated, the accompanying adult will be responsible for payment. For your convenience, we accept Cash, Check, Visa, and MasterCard. Payment is due upon receipt of any mailed statements. There is also a $25.00 fee per completion of certain forms.
- **PHONE CALLS:** In the event of a question during office hours, we are available Monday through Thursday 8:30 am – 4:45 pm and Friday 8:30 am – 2:45 pm. If you leave a message with a staff member, every effort will be made to return your call within 24 hours Monday through Friday. After office hours a call center will take urgent calls and page the neurosurgeon on call if needed.
- **PLEASE DO NOT** leave children unattended in the waiting area. All children under the age of 18 must be accompanied by a parent/guardian. If the parent is not present, the appointment will be rescheduled**.**
- **PATIENT APPOINTMENT WAIT TIME:** Patients are seen in order of appointment time, not time of arrival. Some patient appointments may take longer than expected because of the specialty of our practice.
- **PAIN MEDICATIONS** are typically not prescribed unless a patient has had surgery. If you are in need of pain medication and you have not had surgery within the past 90 days, please contact your primary care doctor or pain management doctor first to request medications.
- **ONLY PETS** that are Certified Service Animals are allowed in the office.

ATLANTIC NEUROSURGICAL & SPINE SPECIALISTS, P.A.

*****PLEASE USE BLACK INK***** PLEASE COMPLETE FORM IN FULL *****PLEASE USE BLACK INK*****

PATIENT: _____
LAST NAME FIRST NAME MIDDLE/MAIDEN SEX

_____
ADDRESS: STREET P.O. BOX CITY STATE ZIP

(_____) _____-_____-_____-_____
HOME PHONE NUMBER DATE OF BIRTH AGE SOCIAL SECURITY NUMBER

(_____) _____-_____(_____) _____-_____
CELL PHONE NUMBER EMPLOYER WORK PHONE NUMBER

EMAIL ADDRESS: _____

_____-_____-_____
SPOUSE'S NAME EMPLOYER DATE OF BIRTH SPOUSE'S SOCIAL SECURITY

_____
NEAREST FRIEND OR RELATIVE TO CONTACT IN CASE OF EMERGENCY HOW RELATED? PHONE NUMBER

Do you have a healthcare Power of Attorney? Yes ☐ No ☐ Do you have a Do Not Resuscitate (DNR)? Yes ☐ No ☐

Race: ○ American Indian or Alaskan Native ○ Asian ○ Black or African American ○ White ○ Native Hawaiian or other Pacific Islander ○ Other ○ Declined **Ethnicity:** ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Declined

REFERRING PHYSICIAN: _____
NAME PHONE NUMBER

FAMILY PHYSICIAN: _____
NAME PHONE NUMBER

REASON FOR VISIT: _____ **ONSET DATE/DATE OF INJURY: _____**

IS THIS A 2ND OPINION: _____PREVIOUS DOCTOR TREATING CONDITION: _____

Pharmacy Name: _____
Name City Phone

PRIMARY INSURANCE: _____ POLICY HOLDER _____
POLICY ID#: _____ GROUP# _____

SECONDARY INSURANCE: _____ POLICY HOLDER: _____
POLICY ID#: _____ GROUP#: _____

IF PATIENT IS A MINOR, PLEASE PROVIDE PARENT INFORMATION
PARENT(S) NAME(S): _____
HOME PHONE #: _____ WORK PHONE#: _____

Under the requirements of HIPPA we are not allowed to give any information to anyone without the consent of the patient. **I authorize Atlantic Neurosurgical & Spine Specialists to release my medical and/or billing information to the following individual(s):**

1._____ Relation to Patient_____

2._____ Relation to Patient_____

3._____ Relation to Patient_____

This authorization is effective through ___/___/___ unless revoked or terminated by the patient or the patients' personal representative in writing by contacting our office at 763-3333. If left blank, authorization will end 2 years from signed date. I authorize that all the above information is correct.

Signature: _____ Date: _____