

Dear: \_\_\_\_\_: Date \_\_\_\_\_

We have received a referral from your physician for you to have a neurosurgery consultation. In order to better serve you, please complete all the forms enclosed with **all pages completed IN FULL & SIGNED**, and return them to the address listed.

This information must be received **before** an appointment with either Dr. Dixon, Dr. White and Dr. Lakatos will be made. Dr. Dixon, Dr. White and Dr. Lakatos **will not accept private insurance on a personal injury claim**. Please do not request that we bill your private insurance. There are few instances when this will not apply and this would be arranged through an attorney.

We must also have a *Letter of Protection* from your attorney. This *Letter of Protection* will cover any future appointments you may have that are related to your injury. We must have the *Letter of Protection* before an appointment will be made.

Payment of your initial consultation is expected at the time of service. Please be prepared to pay \$250.00 at the time of check-in. We cannot bill for this initial date of service. If you are unable to pay at the time of check-in, we will reschedule your appointment.

The following is a list of items we need prior to scheduling your appointment:

- Patient information
- Patient Medical Records & Billing information form
- Patient Assignment to Provider form
- Letter of Protection

The following is what you need to bring with you to your appointment:

- MRI or CT films (no disk format, FILMS ONLY)
- Diagnostic Reports (EMG, myelogram, etc.)
- Plain X-rays
- \$250.00 consultation fee

Thank you for your cooperation and time in this matter. If you have any questions or concerns, please do not hesitate to call our office.

Sincerely,

Teresa Freshcorn  
Practice Manager

**PATIENT ASSIGNMENT TO PROVIDER/PROVIDER SECURITY INTEREST**

This agreement entered \_\_\_\_\_ (date), between \_\_\_\_\_ hereinafter called "Patient" and Dr. Robert Dixon, Dr. Mark White and/or Dr. Ronald Lakatos hereinafter called "Provider." Patient hereby irrevocably assigns to Provider any and all benefits payable by an insurance company as a result of charges incurred by Patient for services rendered by Provider in connection with an accident on \_\_\_\_\_. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company or any other party liable to Patient for payment of medical costs incurred by Patient as a result of services rendered by Provider.

The assignment of benefits and contractual rights to those benefits shall not exceed the total amount of charges incurred by Patient for services rendered by Provider. Patient agrees that payment for services rendered by Provider is due upon receipt of said services. Patient is also fully responsible to Provider for any services not covered by insurance along with any applicable deductible and co-payment. This also includes any care that any insurance may later deem not medically necessary.

Patient also grants Provider a security interest in all of patient's rights arising out of the claim described herein to the extent of medical services provided to Patient. A photocopy of the assignment and security interest shall be considered as effective and valid as the original.

**INSTRUCTION FOR DIRECT PAYMENT**

I HEREBY INSTRUCT AND DIRECT THE:

#1 Insurance Company (patient's insurance) \_\_\_\_\_

Claim Number \_\_\_\_\_

Address \_\_\_\_\_

#2 Insurance Company (other parties insurance) \_\_\_\_\_

Claim # \_\_\_\_\_

Address \_\_\_\_\_

#3 My attorney \_\_\_\_\_, is hereby instructed to make direct payment to:

Columbus Neurosurgical Group, LLC

4995 Bradenton Ave.

Suite 130

Dublin, Ohio 43017

and all other persons or companies responsible for Patient's health care cost to make all payments for medical services rendered by Provider directly to Provider and to pay by check made out to and mailed directly to Columbus NeuroSurgical Spine Group.

If the insurance policy prohibits direct payment to the Provider then I hereby instruct and direct you to make out the check to Columbus Neurosurgical Group, LLC to the above address.

**AUTHORIZATION FOR RECORD RELEASE**

Provider is authorized to release any information deemed appropriate by Provider concerning Patient's physical condition to any insurance company, attorney or adjuster in order to process any claims for reimbursement of charges incurred by Patient.

Provider \_\_\_\_\_ Patient Name \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Medical Records Release & Billing Information  
for  
Columbus Neurosurgical Spine Group**

I hereby authorize Dr. Robert Dixon, Dr. Mark White, Dr. Ronald Lakatos and/or CNS Physical Therapy to bill/invoice and release my medical records in chart format or telecommunications to my legal representative, my insurance company, or the other parties insurance company representative listed below:

**1. Legal Representative/Attorney Office** \_\_\_\_\_

**Attorney's Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Telephone of Attorney** \_\_\_\_\_ **DATE OF INJURY** \_\_\_\_\_

**Fax of Attorney** \_\_\_\_\_

**2. Open MedPay Claim Information (patient's car/home insurance)**

**Name of Insurance Company** \_\_\_\_\_

**Caseworkers Name** \_\_\_\_\_

**Claim Number** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Fax Number** \_\_\_\_\_

**3. Other or Third Parties' Insurance Company (at fault's insurance)**

**Name of Insurance Company** \_\_\_\_\_

**Caseworkers Name** \_\_\_\_\_

**Claim Number** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Fax Number** \_\_\_\_\_

**At Fault Policyholders Name** \_\_\_\_\_

To be released is any information including the diagnosis, records of any treatment, tests, and all medical records from my chart I request released to my insurance company in the form of copy or facsimile, exclusions from this area are:

**NO EXCLUSIONS:** \_\_\_\_\_ **INITIALS:** \_\_\_\_\_

**EXCLUSIONS:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DATE** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**WITNESS** \_\_\_\_\_

PRIVATE HEALTH INSURANCE WAIVER

I, \_\_\_\_\_[PATIENT NAME] request that Dr. Robert Dixon, Dr. Mark White, Dr. Ronald Lakatos, Columbus Neurosurgical Spine Group and CNS Physical Therapy (“the Providers”) NOT bill my insurer for services rendered in connection with or resulting from the injury I sustained on \_\_\_\_\_ [DATE OF INJURY].

I understand that under Ohio law I may have the right to have the Providers seek reimbursement for these services solely from my insurer, other than for required deductibles and co-payments. By making this request, I am waiving that right.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT SIGNATURE

The Providers hereby agree to the restriction requested above.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PROVIDER SIGNATURE