Northtowns Neurosurgery General Practice Policy

At Time of Service: Failure to provide the following may result in rescheduling:

- Social Security Number (if needed for eligibility)
- Current insurance card & billing info
- Photo ID
- Workers' compensation or No-fault claims info (if applicable)
- Co-payment/Co-insurance/Deductible

Privacy Practices: Posted at our location and on our website. A copy is available upon request.

Nondiscrimination: We comply with federal civil rights laws and do not discriminate based on race, color, national origin, age, disability, or sex.

Proxy: An authorized representative form is available for designating someone to sign documents on your behalf.

Authorization for Medical Treatment: I authorize Northtowns Neurosurgery PLLC staff to administer any necessary medical treatment. I have the right to consent or refuse treatment, except in emergencies.

Insurance Assignment: I authorize my insurance carrier to pay Northtowns Neurosurgery PLLC directly for services rendered. I agree to pay any patient responsibility.

Disclosure of Information: My medical records may be shared with office staff, healthcare providers involved in my care, and insurers as required.

Request for Records: We will respond within 30 days. A nominal fee applies for supplies and postage. Records require a signed authorization form, available at the office or via the patient portal.

Request for Forms Completion: A $15 fee per form applies, due at the time of request. Processing takes up to 10 business days.

Use of Mobile Devices: Audio or video recording is prohibited in our offices. Please refer to our posted mobile device policy.

Appointment Cancellation/No-show: A 24-hour notice is required to cancel appointments. Failure to do so may result in a No-Show fee up to $50.

Discharge from Practice: You may be discharged for policy violations, missed appointments, disruptive behavior, or non-payment. Discharged patients cannot schedule future appointments with Northtowns Neurosurgery PLLC providers.

I have read and agree to the above policies and accept responsibility for financial obligations. I will notify Northtowns Neurosurgery PLLC of any changes to my information.

Patient Signature: _____ **Date**: _____