



## Office Policies

**Medical Consent:** I consent to all care, treatment, diagnostic imaging, laboratory testing and other medical procedures performed or prescribed by a physician of Orlando Neurosurgery and his/her designees.

**Right of Refusal of Treatment:** I understand that I have the right to make informed decisions regarding all aspects of my care. I should ask my health care provider to further clarify and explain anything I do not understand. I have the right to refuse treatment.

**Acknowledgement of Receipt of Patient Rights & Notice of Privacy Practices:** I have acknowledged that I have received both notices, Notice of Patient Rights/Responsibilities and HIPPA Notice of Privacy Practices.

**Release of Medical Information:** I authorize Orlando Neurosurgery to release any information necessary to facilitate healthcare processing of claims, or audit of payments in relation to my care and treatment. I also consent to the release of any information needed to other facilities, agencies or healthcare providers as per Orlando Neurosurgery's discretion. This order will remain in effect until revoked by me in writing.

**Financial Policy:** I certify that the insurance information I have provided to Orlando Neurosurgery is accurate, complete and current. I certify that no other coverage of insurance exists. It is my responsibility to understand the terms and benefits of my insurance plan. I understand I am financially responsible for charges not paid by my insurance. I may be required to pay co-payments, co-insurance or deductibles at the time of service unless other arrangements have been made in advance. Orlando Neurosurgery will make every attempt to notify me in advance if a service is not covered. If my insurance company has not paid my bill in full within 60 days, I will be expected to pay the remaining balance within 30 days. In the event of a large balance due from an operation, Orlando Neurosurgery may be able to arrange a payment plan suitable for all parties concerned.

**Forms & Medical Records:** If you require our office to complete any forms, there is a charge of \$15 per form. Forms will be completed within 10-14 business days. If you require a copy of your medical records, you must sign a Medical Records Release form and a payment of \$1.00/page for the first 25 pages, then \$0.25/page after that will be due upon receipt of your request. Your request will be completed within 10-14 business days.

**Appointment No Show / Cancellations:** If it is necessary to cancel/reschedule your appointment, please do so 24 hours PRIOR to the time of your scheduled appointment. If you do not cancel an appointment or no show, you will be responsible for a \$25.00 charge. The fee of \$25.00 is to be paid by the patient and is not billable to any insurance.

**Surgery Cancellations:** If you must cancel a scheduled surgery, please notify our office by 12:00PM ten (10) business days (Monday – Friday) prior to your surgery to avoid a cancellation fee of \$250.

**Dispensing of Opioid (Narcotic) Pain Medications:** In response to the "Opioid Crisis", The State Legislature of Florida passed the Controlled Substances Bill (CS/CS/HB 21) which regulates the prescribing of Schedule II and Schedule III pharmaceuticals. These regulations affect the prescriptions your providers are allowed to prescribe you after surgery. Schedule II narcotics are limited to a three (3) day supply for "acute pain exception". A seven (7) day supply can be provided under special circumstances. Our office will limit dispensing schedule II and III prescriptions to 14 days post-op. It is important to understand that Orlando Neurosurgery does not manage chronic pain. If you need chronic pain management, we are happy to provide a referral to a pain management specialist.

**Return of Imaging CDs/Films:** It is important for our providers to review your images for proper diagnosis and treatment; however, our office does not have the capacity to store these films. A copy of your images will be downloaded to our system at your appointment. Your images will be returned to you at the end of your appointment. If you leave your images for any reason past your appointment date, we will store them for 90 days as a courtesy. During this 90 days, you have the option to pick them up on the office at no charge, or we can ship them to you for a \$10 service and handling fee. After 90 days, any remaining CDs/films will be disposed per HIPAA guidelines.

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Patient Signature

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Printed Name

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Date