ORANGE COUNTY NEUROSURGICAL ASSOCIATES

Drs. Kim and Taghva
26732 Crown Valley Parkway, Suite 541
Mission Viejo, CA 92691

Tel: (949) 388-7190
Fax: (949) 388-7150

It is the policy of Drs. Kim and Taghva to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish our office to bill an insurance company, a copy of the insurance card (front and back) and/or complete billing information is required and must be presented before services are rendered. The billing information required is the correct billing name, address, phone number, the I.D./subscriber number, and group/policy number. We also need the name of the insured along with the date of birth and name of employer.

Enrollment in an insurance plan is not a guarantee of payment.

Deductibles, co-payments and patient responsibility amounts are due at the time of service.

Drs. Kim and Taghva do not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan **before** services are rendered. This also applies to any facility or provider your doctor may refer you to.

Any portion of the balance not paid by the insurance company due to patient co-pays, deductible amounts, non-covered services, services deemed by the insurance company as not medically necessary, doctor nonparticipation in a plan or any other reason for nonpayment or reduced payment is the responsibility of the patient or responsible party. It is the policy of this medical group to receive payment in full 90 days from the date of service.

HMO's and other insurance plans that require an authorization for treatment from a Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self-referrals and services provided by out of network providers are usually not covered. **Authorization does not guarantee payment by the insurance company.**

A statement of charges will be sent to the patient or responsible party each month showing the portion billed to the insurance company and the patient due balance. Balance is due and payable 90 days from the date of service. Delinquent balances may be referred to an outside agency for collection.

We accept cash, check, money order, Mastercard, VISA, and Discover as your method of payment.

The fee for a returned check is $15.00.

I have read the above policy and understand I am financially responsible for all medical services rendered.

Signature of Patient or Responsible Party	Date

Print Name

Authorization to disclose information to Family members and friends

HIPAA Message Authorization

Please fill out this form so that your doctors can receive your information

I, ________________________ (sign your name here), authorize Drs. Kim and Taghva to disclose my personal medical information to **the following people:**

____

This authorization will remain in effect until revoked by the patient. I understand I have the right to revoke or terminate this authorization by submitting a written statement to Drs. Kim and Taghva. I understand that the information disclosed can in turn be disclosed by the members or organizations who have received the information, and, that such disclosed information cannot be protected under federal privacy regulations.

Unless specified, Drs. Kim and Taghva will divulge information strictly in the clinic or hospital direct setting. Should you wish to be contacted with potentially private information in other ways, please click on the areas below:

___ ok to leave message on cell phone

___ leave a message with call-back number only

___ ok to email at the following address: ________________________ (privacy cannot be guaranteed)

___ ok to leave message on home phone with detailed message

For any further questions regarding Drs. Kim and Taghva's privacy practices, please feel free to discuss directly with the doctors. This notice describes how the doctors may use and disclose patient's protected health information, certain restrictions on the use and disclosure of healthcare information dissemination, and the rights each patient has regarding privacy and protection of information.

NAMES OF DOCTORS WHO WILL RECEIVE YOUR INFORMATION

Primary care physician: ____

Pain management doctor ____

NEUROLOGIST: ____