William M. Banister M.D.
NEURO-SPINE

Patient Bill of Rights

Patient Name: _____ **DOB:** _____ **Date:** _____

As a patient being treated in our office you have a right to:

- To respectful care given by competent personnel.
- To have consideration of your privacy concerning your own medical care.
- To know the name of all physicians and/or staff directly assisting in your care.
- To have medical records pertaining to your medical care treated as confidential (except as required by law or third party contracted agreement).
- To expect emergency procedures to be implemented without delay; if there is a need to transfer you to another facility the responsible person and facility will be notified of your condition prior to your arrival.
- To have good quality care and high professional standards that are continually maintained and reviewed.
- To have full information in layman's terms concerning diagnosis, treatment, prognosis and possible complications.
- To give an informed consent to the physician prior to the procedure.
- To be advised of participation in a medical care research program or donor program. (you will be asked to give your informed consent prior to participation in such a program and you may refuse to continue in a program that you may have previously given informal consent to participate in).
- To refuse drugs or procedures and have a physician explain the medical consequences of your refusal.
- To be given medical and nursing services without discrimination based upon age, race, color, religion, national origin, handicap, disability or source of payment.
    - To have access to an interpreter whenever possible.
    - To have access to all information contained in your medical record unless access is prohibited by law.
    - To expect good management techniques to be implemented that consider effective use of your time and avoid unnecessary discomfort.
    - To be able to examine and receive a detailed evaluation of your bill.
    - To be informed at your request of your provider's credentials.

Patient Responsibility Statement

The patient has the responsibility to:

- To provide the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- To participate in health care decisions and following the treatment plan outlined by the practitioner responsible for his/her care. This includes following instructions of the physicians, nurses, and other health care personnel carrying out the plan of care and enforcing rules and regulations.
- For assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible and in the case of financial difficulty, making all reasonable efforts to meet any agreed upon financial payment plan.
- Responsibility for his/her actions if he/she refuses treatment or is non-compliant in following a plan of treatment recommended by his/her physician.
- To make sure he/she understands all information regarding the implications of his symptoms, surgery or procedure (if applicable) and any risks related to having or declining such surgery or procedure, the expected outcomes of the plan of care outlined by this physician, and his responsibilities in regard to that plan of care.
- To be made aware of advanced directives, living wills, and the limitations, if any, to comply with such a request.
- To refuse any drug regimen he/she does not feel is necessary and assume the risks involved in such refusal.
- To change providers at any time or gather a second opinion from another provider.
- To provide urine sample for purposes of drug screening and adhere to the opioid agreement.
- To provide transport and a responsible caregiver after any procedure if directed to do so by the provider or physician.

Acknowledgement of Receipt of Notice

Patient Signature: _____ **Date:** _____

O: **(972) 499.4280** | F: **(214) 812.9688**
A: **5575 Warren Parkway, Professional Building 1, Suite 314**
Frisco, TX 75034-4092
WWW.BANISTERMD.COM

William M. Banister M.D.
NEURO-SPINE

Office Policies

Consent and Insurance Authorization for Treatment and Billing

Patient Name: _____ **DOB:** _____ **Date:** _____

Billing Notice:
I hereby authorize the physicians at William M. Banister, MD, PA to provide medical treatment, release information pertaining to treatment deemed necessary by my insurance companies, attorney or referring physician, and to receive direct payments for professional treatment otherwise payable to me for service rendered. My insurance carrier or I may revoke this authorization at any time in writing. I hereby authorize direct payment of medical benefits provided by my insurance policies to the above named physicians. I understand and agree to be responsible for any portion of this claim that for any reason is not covered by my insurance, otherwise provided by law. I further understand that any legal fees incurred to collect this claim are my responsibility.

Waiver:
If I am a member of a HMO insurance and the Physicians at William M. Banister, MD, PA, are not participating members, or I choose to be treated without a referral or authorization, I acknowledge that I am fully responsible for any and all charges incurred as a result of my decisions to be treated by William M. Banister, MD, PA. I understand and agree that I am financially responsible to William M. Banister, MD, PA for co-pays, deductibles, and non-covered items as outlined in my insurance policy contract. I hereby certify that the information above is correct.

For Health Insurance Cases:
It is your responsibility to adhere to all of the regulations and requirements of your health plan, in or out of network. If your health insurance plan requires you to obtain a written referral and/or authorization number from your Primary Care Physician for your office visit or procedure, you must supply us with the referral/authorization number. If you do not, you will be responsible for the entire charge for the date of service.

Patient Signature: _____ **Date:** _____

We require showing your insurance card at each visit, so we can verify the information that is in our system.

In Network:
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment and any additional percentage (co-insurance and/or deductible) due. You could be billed for any remaining amount after the services are rendered.

Please be advised that William M. Banister, MD, PA, are associated entities that function under different Tax ID numbers and bill for services separately and therefore insurance participation may vary and you may be responsible for the balance not covered under your insurance plan.

Insurance, Billing and Privacy Notice Acknowledgement:

I have received and read the above information in this packet, which includes the company's referral policy, the billing information, and the Notice of Privacy Practices. I have read and acknowledge the policies of William M. Banister, MD, PA, as stated above. I understand failure to comply with these policies may result in the discontinuation of my treatment with the said facilities.

Patient Signature: _____ **Date:** _____

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