FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

Specializing in the treatment of spinal meningeal cysts

WORKER'S COMPENSATION/LIABILITY/LEGAL/AUTOMOBILE RELEASE

FEIGENBAUM NEUROSURGERY, P.A. has discussed with you on the phone our medical practice policy of not accepting Worker's Compensation, Liability, Legal claims, and/or Automobile Injury patients. Based on our conversation with you, we understand that your possible diagnosis of symptomatic Tarlov cysts is **not** currently related to your filed Worker's Comp, Liability, Legal, and/or auto claim(s).

FEIGENBAUM NEUROSURGERY's medical practice policy requires that you agree, in writing, prior to scheduling your initial consultation, that any medical claims related to your medical visit for symptomatic Tarlov cysts, will **not** be included in any current or future Worker's Comp, Liability, Legal, and/or auto claim(s).

When you return this signed document, we will schedule you for an initial consultation visit. We will bill your commercial insurance for this consultation and any future surgical treatments that may be medically necessary. If your commercial insurance refuses to pay, then you will be responsible for medical services, as a self-pay patient.

If you have a previous worker's compensation, liability, legal, and/or automobile liability claim(s), you will be **required** to provide documentation stating your previous claim(s) is **closed** or if an automobile claim, the **funds have been exhausted**, on the worker's comp/liability/automobile company's letterhead. The documentation must include your **name, date of injury, and claim number**; an attorney's letter will **not** be accepted.

I, _____ (patient name), attest that I have not filed any worker's compensation, liability, legal, and/or automobile claim(s).

I, _____ (patient name) agree that I will not pursue worker's compensation, liability, legal, and/or automobile liability claims before or after my services are rendered with FEIGENBAUM NEUROSURGERY, P.A. This includes any legal consultations such as depositions, IMEs, letters, or communications with any legal representation on behalf of the patient. Medical records will only be provided upon written request with patient's signed release.

I, _____ (patient name) agree that any medical services will be billed to my commercial insurance carrier. If my insurance company decides to deny services, I will be financially responsible and will be considered a self-pay patient. It is my responsibility to keep in contact with staff regarding any denied claims. If I do not have insurance, I will be self-pay, and a payment plan will be determined before services are rendered.

If a previous claim, I, _____ (patient name), agree to provide the proper documentation from the worker's compensation, liability, or automobile's company.

Your signature is acknowledgement that you have read and agree with FEIGENBAUM NEUROSURGERY's medical practice policy outlined in this letter.

If you have any questions, do not hesitate to contact our office at 214-242-1389.

_____ _____
Patient Signature Date

_____ _____
Patient Name DOB

_____ _____
Witness Signature: Date

_____ _____
Witness Name: Relation:

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