NEUREPAIR
BRAIN & SPINE
WELLNESS CENTERS

Neurosurgery

New Patient Intake Form **Date: _____**

I. Demographic Information

Name: _____ D.O.B._____ M_____ F_____

Home Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email address: _____ Pref: Text_____ Email_____

II. Care Information- please list complete name and address of physicians and pharmacies

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Referring Physician (if different from PCP) _____ **Specialty:** _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Preferred Pharmacy: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

III. Chief Complaint (Reason for your visit): _____

_____

Is this related to worker's compensation? Yes_____ No_____
Is this related to any legal actions? Yes_____ No_____
Is this problem the result of an accident? Yes_____ No_____ If so, when did the accident occur?_____

Please list **all Medications** you take routinely, prescribed or over-the counter, along with the dosages:

Medication:	**Dose:**	**Frequency:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **Allergic** to any medications, latex, X-ray dye, or iodine? (circle one) Yes No

If yes, please explain (reaction): _____

Are you taking any "blood thinning" medications? (Circle one) Yes No

If yes, check all that apply: Aspirin _____ Anti-inflammatory medication _____ Plavix _____

Coumadin _____ Fish Oil _____ Other (specify): _____

IV. Medical History	**Please list all active medical conditions:**	**Onset of Condition:**
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

IV. Surgical History	**Please list all operations you have had:**	**Date (Mo/Yr):**
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

VI. Family History Do you have a family member affected with:

Condition	**Yes**	**No**	**affected relative**	**Condition**	**Yes**	**No**	**affected relative**
Cancer (non brain)	□	□	_____	Bleeding/Clotting	□	□	_____
Glioma	□	□	_____	Heart disease	□	□	_____
Meningioma	□	□	_____	High Cholesterol	□	□	_____
Brain Aneurysm	□	□	_____	Hypertension	□	□	_____
Other Aneurysm	□	□	_____	Diabetes	□	□	_____

Other conditions: _____

_____

	Alive	**Deceased**					
Father	□	□	No. of Siblings:	Brothers	_____	Sisters	_____
Mother	□	□	No. of Children:	Sons	_____	Daughters	_____

VII. Social History

Occupation: _____ Marital Status: _____

Hobbies: _____

Do you exercise regularly? Yes ____ No _____ How frequently? _____

Do you smoke? Yes___ No____ Cigarettes_____ Cigars_____ Other_____ If so, how much?_____

Do you use other forms of tobacco? Yes___ No____ If so, specify type ?_____

Do you drink alcohol? Yes____ No_____ If so, how much?_____

Do you use recreational drugs? Yes____ No_____ If yes, specify type? _____

Females: Are you, or could you be, pregnant? _____

VIII. Review of Symtoms Do you currently, or have you had a problem with:

Constitutional:		
Difficulty sleeping	Yes	No
Excessive fatigue	Yes	No
Fever	Yes	No
History of falls	Yes	No
Weight gain	Yes	No
Weight loss	Yes	No
Eyes:		
Wear glasses	Yes	No
Cataracts	Yes	No
Double/blurry vision	Yes	No
Glaucoma	Yes	No
Infections	Yes	No
Injuries	Yes	No
Ear,Nose,Throat, & Mouth:		
Wear hearing aids	Yes	No
Earpain/infections	Yes	No
Hearing loss	Yes	No
Nasal congestion/drainage	Yes	No
Nose bleeds	Yes	No
Ringing in ears	Yes	No
Sinus pain	Yes	No
Cardiovascular:		
Chest pain or Angina	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Irregular pulse	Yes	No
Leg pain while walking	Yes	No
Swelling in hands/feet	Yes	No
Respiratory:		
Asthma	Yes	No
Bloody sputum	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Shortness of breath	Yes	No
Gastrointestinal:		
Abdominal pain	Yes	No
Change in bowel habits	Yes	No
Diarrhea/constipation	Yes	No
Jaundice	Yes	No
Nausea	Yes	No
Ulcers or gastritis	Yes	No
Vomiting	Yes	No

Endocrine:		
Diabetes	Yes	No
Excessive thirst/urination	Yes	No
Thyroid disease	Yes	No
Genitourinary:		
Blood in urine		
Difficulty starting/stopping stream	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Painful urination	Yes	No
Musculoskeletal:		
Arm/leg pain	Yes	No
Arthritis	Yes	No
Joint pain/swelling	Yes	No
Numbness/tingling in extremities	Yes	No
Shoulder pain (left/right/both)	Yes	No
Weakness in arms/legs	Yes	No
Integumentary:		
Skin disease	Yes	No
Neurological:		
Difficulty with balance	Yes	No
Difficulty with speech	Yes	No
Disorientation		
Dizziness	Yes	No
Fainting spells/black outs	Yes	No
Headaches	Yes	No
Inability to concentrate	Yes	No
Loss of sensation/numbness	Yes	No
Memory loss	Yes	No
Pain in neck/back	Yes	No
Seizures	Yes	No
Psychiatric:		
Anxiety	Yes	No
Depression	Yes	No
Hematologic/Lymphatic:	Yes	No
Anemia	Yes	No
Bleeding tendencies	Yes	No
Blood transfusions	Yes	No
Hemophilia	Yes	No
HIV	Yes	No
Persistent swollen glands/lymph nodes	Yes	No
Allergic/Immunologic:		
Autoimmune disease	Yes	No
Food and/or inhalant (nasal) allergies	Yes	No

IX. Pain Assessment

Do you experience pain as part of your daily life? Yes No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

_____
_____
_____
_____

If yes, on a scale of 0 to 10, (O = no pain, 10 = the worst pain) how would you rate your pain? _____

Have you ever had pain injections? _____ If yes, when? _____

What type of injection?_____

X. Handedness

Are you: Right handed Left handed

XI. Do you have a Health Care Proxy? Yes No

If yes, please list: _____

XII. HIPAA Release (please check one)

I **do** _____ **do not** _____ consent to allow Neurepair to share the above information with other providers involved in my care, as well as to disclose and obtain all medical records, including lab tests, diagnoses, treatment, and billing pertinent to my care. I consent to release my medical information to payore involved in my medical care.

XIII. Emergency Contact

Name: _____ Phone: _____

Relation: _____ Alt. Phone: _____

I **do** _____ **do not** _____ consent to allow Neurepair to share information with my emergency contact, including but not limited to all medical records, diagnoses, and treatment.

I attest that the information on this form is accurate to the best of my knowledge:

_____ _____

Patient signature Date completed

I have reviewed the above information:

_____ _____

Provider signature Date completed

NEUREPAIR

PATIENT CONSENT AUTHORIZATION

Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures when warranted. I understand that I am under the care and supervision of the attending physician, and it is the responsibility of the staff to carry out the instructions of such physician(s). **Yes ____** **No ____**

Authorization for Medical Treatment: This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis, and prognosis. You are authorized to provide this information in accordance with the Florida "NO FAULT" auto insurance law (Chapter 71-252 F.S.) **Yes ____** **No ____**

Authorization to Photograph or Video: This authorization or photocopy hereof, will authorize you to be photographed for treatment purposes related to your healthcare, professional activities, insurance claims and patient condition. **Yes ____** **No ____**

Consent to Treat Minor Child: I am the parent or legal guardian of the patient and do hereby consent to any medical care of the providers of NeuRepair Brain and Spine Wellness Centers to determine what's necessary for the welfare of my child while said child is under their care.

Yes ____ **No ____**

Parent or Guardian Consent to Accompany Minor Child: I am the parent or legal guardian of the patient (minor child) and authorize the following individual to accompany my child to their medical office visits in my absence: _____

First name Last name

(Must provide photo ID that matches this individual's name)

Patient's Printed Name: _____

Patient of Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NEUREPAIR
BRAIN & SPINE
WELLNESS CENTERS

Notice of Office Policies

1) Audio and/or video recording is strictly prohibited without the expressed consent of the provider. It is illegal in the state of Florida to record your provider without his/her/their consent. There are sensitive patient documents (HIPPA) and patient information in the building. If you are observed engaging in illegal activities on the premises, you will be discharged from the practice.

Initials: _____

2) Diagnostic images (MRI, CT, X-rays etc.) may be used for teaching or instructional purposes. No personal identifying data will be used.

Initials: _____

3) In order to respect and accommodate all patients, patients are allowed a 15-minute grace period if they are running late and provide notice. If a patient is greater than 15 minutes late, he/she/they will be subject to the cancellation of his/her/their scheduled appointment and may be charged a "no-show" fee.

Initials: _____

4) No-show fees for follow-up visits are charged based on the type of visit, and range between $95-$200. No-show fees for injection appointments are $250. No-show fees for surgery are $415.

Initials: _____

5) The cancellation and/or rescheduling of 3 office appointments and/or surgeries by the patient may result in the discharge of that patient from the practice.

Initials: _____

I have read and understand the above information:

_____ Date: _____
Patient Signature

_____
Printed Name

10/2022

Florida Patient's Bill of Rights Acknowledgement

As a new patient at our health care facility, we would like to take this opportunity to advise you or your rights and responsibilities which requires that we adopt and make available to all patients, in writing, a statement of the rights and responsibilities of patients, including the following:

Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect your health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of this or her individual dignity, and with protection of his or her need for privacy.

- **A patient has the right to a prompt and reasonable response to questions and requests.**
- **A patient has the right to know who is providing medical services and who is responsible for his or her care.**
- **A patient has the right to know what patient support services are available, including whether an Interpreter is available if he or she does not speak English.**
- **A patient has the right to know what rules and regulations apply to his or her conduct.**
- **A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.**
- **A patient has the right to refuse any treatment, except as otherwise provided by law.**
- **A patient has the right to be given upon request, full information and necessary counseling on the availability of known financial resources for his or her care.**
- **A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.**
- **A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.**
- **A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.**
- **A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.**
- **A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.**
- **A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.**
- **A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.**
- **A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health care.**
- **A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.**
- **A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.**
- **A patient is responsible for keeping for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.**
- **A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.**
- **A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.**
- **A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.**

***By signing below, I acknowledge that I have received a Summary of the Florida Patient's Bill of Rights.**

Patient or Guardian Signature **Date:**

Witness (Medical Provider) Signature **Print name**

Notice of Privacy Practices

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) along with brief overview of our Notice of Privacy. Our practice is complying with HIPPA regulations.

What is HIPPA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPPA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The privacy Rule was created to protect your rights as a patient of our practice, and we are required by law to be compliant with this regulation. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?

Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted, and a copy is provided in our waiting room, and you can take a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Appointment reminders	Release of Information to Family/Friends
Payment	Treatment Options	Disclosure Required by Law
Health Care Operations	Health-Release Benefits & Services	

The following categories describe unique situations in which we may use or disclose your Identifiable Health Information:

Public Health Risks	Health	Oversight Activities	
Lawsuits and Similar Proceedings	Law Enforcement	Deceased Patients	Organ and Tissue Donation
Serious Threats to Health or Safety	Research	Military	
National Security Inmates	Workers' Compensation		

What are your rights concerning your individually Identifiable Health Information (IIHI)?

Your have rights regarding the IIHI that we maintain about you. In our Notice of Privacy, you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper copy of this Notice
7. Right to file a complaint
8. Right to provide an Authorization for other uses and disclosures

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

I have read the short notice provided by NeuRepair Brain and Spine Wellness Centers, and have been informed of how to obtain more information regarding our Notice of Privacy.

Patient's printed name: _____

Patient or Guardian Signature: _____ Date: _____

NEUREPAIR
BRAIN & SPINE
WELLNESS CENTERS

Fee Transparency Attestation

NeuRepair Brain and Spine Wellness Centers provides various services and consumable products. Services include professional fees such as office visits, procedures, surgery fees, and independent opinions. Consumable products include medications used for injections, braces or collars for neck and back fractures or for after surgery, and certain medications useful and pertinent to your clinical scenario. There are also fees for X-ray services, stem-cell injections, and other therapies which are employed where clinically appropriate in your treatment.

Fee schedules for some of the most common office visit types, therapies, medications, braces injections and surgeries are readily available to you. You also have a choice when it comes to Healthcare and are entitled to more than one opinion. You are also entitled to more than one quote for any proposed surgery, injection, or medication.

__ I understand that if I am being treated in relation to a liability injury, my health insurance may not be billed unless appropriate.

__I understand that I have the right to take a prescription to an outside pharmacy to fill some of my pertinent medications.

__I understand that I have the right to take a prescription to a different facility to get my cervical collar/lumbar brace.

__I understand that the prices for consumable products, medications, professional fees, and other fees which NeuRepair Brain and Spine may be higher or lower than some other options available to me.

__I understand there is a fee schedule for all products, medications, and professional fees available to me.

_____ _____

Patient Signature **Date**

_____

Printed Name

FINANCIAL RESPONSIBILITY POLICY

Name of Patient: _____

Medical Provider: NeuRepair Brain and Spine Wellness Centers,
8140 Picton Way, Suite #102, Trinity, FL. 34655

As a new patient of our facility, we would like to advise you of our Financial Responsibility Policy. The number of benefits will depend on your policy and the circumstances of your case. Also, insurance companies may deny claims in whole or part, making it almost impossible to determine how much of your claim will be covered.

Patients are responsible for the payment of all covered medical expenses that are not paid by applicable insurance. Your financial responsibility, if any, cannot be determined until (a) you have completed treatment, and (b) the financial obligations of your insurance company have been determined. In some instances, it will take litigation to obtain insurance company payment which can take months, if not years to resolve. In consideration of and as an express condition to our agreeing to providing treatment to you and waiting to obtain what, if any insurance payments we will receive, you agree to pay any remaining balances owed for services rendered.

By signing below, I acknowledge that I understand the above Patient Financial Responsibility Policy.

_____ _____
Patient or Guardian Signature **Date**

_____ _____
Witness Signature **Date**

NEUREPAIR
BRAIN & SPINE
WELLNESS CENTERS

Financial Responsibility Form

Patient Name: _____ Acct # _____ Date: _____

I, _____hereby agree and understand that NeuRepair Brain & Spine Wellness Centers has agreed to provide me with medical care and treatment for injuries/conditions which may have been sustained as a result of an incident on _____. I understand that my medical charges will be submitted to my no-fault insurance, the at-fault parties' insurance, and/or any first party automobile insurance, as they are the primary payors in a liability claim. Because health insurance/Medicare are not the primary payors in a liability claim, NeuRepair Brain & Spine Wellness Centers have previously received denials, failures to pay, and requests for refunds. As such, I understand and agree that NeuRepair Brain & Spine Wellness Centers will not submit my medical charges to my health insurance and/or Medicare, that I am ultimately financially responsible to satisfy any and all outstanding medical charges incurred, and that I will be billed for any balances due.

By signing below, I am acknowledging that I have read and fully understand this agreement.

_____ _____

(Print) Patient Name Patient Signature Date

Personal Injury Intake Questionnaire

Details of Present Incident:

Patient's name:_____ Date of Accident:_____ Today's date:_____

Contact ph #s _____ Attorney Name:_____

If the incident was a <u>Motor Vehicle Incident</u> please fill out the following: If not, what kind of incident? _____

Were you the: Driver _____ Front seat passenger_____ Back seat passenger_____Pedestrian_____ On the job_____ Other_____

Do you own a vehicle of your own? Y____ N_____ If yes, name of auto insurance:_____

If no, do you live with a blood relative that owns a vehicle? Y_____ N_____

If yes, name of auto insurance:_____

If no, name of auto insurance of vehicle you were in at the time of the incident_____

Is the auto insurance a Florida Policy? Y_____ N_____ If no, what state? _____

Policy #_____ Claim # _____

Relation to insured: Self _____ Spouse _____ Child _____ Other _____

If not the insured, name of insured: _____ Relation to policy holder_____

Description of vehicle you were in? Make _____ Model _____ Year _____

Was your vehicle stopped at the time on the incident? Y_____ N _____

Was your vehicle moving right before the moment of impact?

Did the vehicle you were in, hit a vehicle(s)/object/person? Y _____ N _____

If yes, what part of your vehicle/object/person did you hit? _____

Did a vehicle(s) or object hit your vehicle first? Y_____ N _____

If yes, what part of your vehicle was hit? (i.e., front, back, side) _____

Seatbelt: Worn_____ Not worn _____ Don't know_____ Airbag deployed: Y ___ N ____ Vehicle does not have air bags_____

Aware of crash: Aware____ Surprised _____ Did you brace yourself? Y ___ N ____ If yes, with arms____ legs____ both_____

After the incident

Unconscious? Y ____ N ____ If yes, unconscious for _____ (unit of time)

After the incident, I had pain in the following areas: Head ____ Neck ____ Mid back____ Low Back ____

Rt shoulder ____ Lt shoulder ____ Rt elbow ____ Lt elbow____ Rt wrist ____ Lt wrist____ Fingers ____

Rt hip ____ Lt hip ____ Rt knee ____ Lt knee ____ Rt ankle ____ Lt ankle ____ Rt foot ____ Lt foot ____

Symtoms first appeared: Immediately _____ (min/hrs) after the incident_____ Next day or longer_____

Did you receive paramedic attention? Y ____ N ____ Did law enforement investigate the scene? Y ____ N ____

After the incident, I went: Home____ Work ____ Hospital ____ Family Physician ____ Other _____

If you went to a Hospital of a medical center:

Name of Hospitl/Medical Center _____

How did you get there? Ambulance____ Relative _____ Friend _____ Other _____

Did you sustain any broken bones Y ____ N ____ If yes, which one(s): _____

Did you have imaging done due to the incident? Y _____ N _____ If yes, which: CT _____ MRI _____ Xrays_____

What body parts were images done of? _____

Were you prescribed: Pain meds. ____ Muscle relaxers _____ NSAIDS (Anti-inflammatory) Other _____

The information provided above is true and correct to the best of my knowledge.

Patient or Guardian Signature: _____

Interviewer Signature: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.