NEUROLOGICAL SPECIALTIES

Financial Policy/Agreement for Services

Thank you for choosing Neurological Specialties. We are committed to providing you with high quality, compassionate healthcare. We believe communication is an important component of a strong physician-patient relationship. Your clear understanding of these policies is important to our professional relationship.

Records: Please allow 10 working days for preparation of forms and letters. The fees must be paid in advance as follows:

- $75/page for form completion.
- $25/page for special letters that require transcription services.

There is no charge for completion of workers' comp forms (DWC) or forms which an insurance company has agreed to pay.

Returned Checks: A $25 fee will be charged for any returned checks. This fee and the amount of the check will be charged to the patient account and must be paid before additional services can be provided. We will attempt to contact you when we receive notification of a returned check via telephone; however, if we are unsuccessful in reaching you, we will follow-up with a written communication to notify you of the charges.

Cancellation Policy: If you cancel, reschedule and/or no-show twice consecutively (without coming in for an appointment in between) you will be required to pay a fee before we will be able to schedule another appointment for you. Those fees are as follows:

- New Patient appointment: $250
- Follow-up Office Visit: $100

Financial Responsibility: Payment of insurance co-pays, co-insurance, deductibles and any unauthorized or out of network services are due at the time services are rendered. We accept the following forms of payment: cash, checks and all major credit cards.

Account Balances: We make every effort to ascertain correct information from your insurance company regarding fees for upcoming services. However, after your insurance has been billed, you are responsible for the remaining balance including co-insurance, deductibles, and any unauthorized or out of network services. Payment for these balances is expected within 60 days. If you are unable to pay within this timeframe, please contact our billing department. We are willing to negotiate payment arrangements to enable you to avoid additional action. Account balances older than 90 days will be charged 10% interest and will be sent to collections, which will negatively impact your credit score.

Insurance Participation: It is important for you to take a proactive approach with regard to your insurance coverage as it pertains to the services you will receive as a patient in our office. We participate with many insurance plans; however, it is impossible for us to be able to guarantee the benefits of your specific coverage. Our billing department can provide you with applicable fees to enable you to understand the financial obligations outside of your insurance coverage.

It is your responsibility to keep us updated with your correct insurance information. If the insurance information is incorrect, you will be responsible for payment of the incurred services and you will be responsible to submit those charges to the correct plan for reimbursement.

Payment in full is expected at the time of service if we do not participate in your insurance plan, or if you are a self-pay patient.

By my signature below, I hereby authorize and direct my insurance company to issue payment directly to Neurological Specialties for medical services rendered on my behalf. If I receive payment for these services from my insurance company in error, I understand I am obligated to forward the money immediately to Neurological Specialties.

I understand that services rendered by Neurological Specialties and its physicians, technicians and/or employees are a necessary part of the medical care for which I have been referred to this office to receive. I hereby consent to and authorize the administration of the recommended services. I authorize Neurological Specialties to obtain or secure any medical records as may be required for continuity of care on my behalf.

By my signature below I confirm I have read and fully understand these policies. I have been given an opportunity to ask questions and receive a copy of this document.

Patient or Responsible Party Signature: _____ Date: _____

Patient Name: _____ DOB: _____