The Clinic for Neurology, P. A. Financial Policy

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. We are committed to providing you with the best possible care. The following is our financial policy:

Payment:

1. All co-payments, coinsurance and deductibles are due and payable at the time of service, regardless of who brings the patient in for their appointment. Sitters, grandparents, divorced parents, etc., must be prepared to pay at the time of service. The Clinic for Neurology, P. A. accepts cash, credit/debit cards (Discover, MasterCard, and Visa). We reserve the right to assess a service charge to accounts that require multiple billing for co-payments.
2. There is a $35.00 charge for returned checks. We serve the right to report returned checks to the Madison County District Attorney's Worthless Check Unit. After receiving one returned check, The Clinic for Neurology will only accept cash or credit/debit card payments for future balances.
3. If you need financial assistance or have questions, please contact our billing department.
4. If you fail to meet financial obligations agreed upon in the financial policy or other payment arrangements made with The Clinic for Neurology, P. A., your outstanding balance will be sent to a collection agency and you will be required to pay the entire amount plus any collection agency fees before being scheduled for any future appointments.
5. Over-payment will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed within 30 days of your written or verbal refund request.
6. The Clinic for Neurology, P. A. requires a 24 hour notice to cancel or reschedule an appointment. If the office is closed due to a weekend or holiday, you will need to call the previous business day to change or cancel your appointment. **If our office is not notified 24 hour prior to a routine office visit, you will be charged a $25.00 fee. For any procedures or test, you will be charged a $50.00 fee**.

Insurance:

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your insurance card and driver's license to each visit and to notify us of any changes.
   - Know you co-payment amount and be prepared to pay this amount at each visit.
   - Know your insurance company benefits (physical exam coverage, diagnostic testing co-payment amounts, and per-certification requirements, etc.)
   - If you are enrolled in a Managed Care Insurance Plan (HMO), it is your responsibility to obtain or ensure a referral is supplied to our office from your primary care physician prior to the time of your appointment. If we do not have your referral by the time of your appointment, The Clinic for Neurology, P. A. has the right to reschedule your appointment to a later date.
1. It's the patient's responsibility to make sure we participate with your plan. If your insurance coverage is through a plan The Clinic for Neurology, P. A. does not participate with, our office will file it for the patient as a courtesy. However, you are responsible for payment in full at the time of service and you will be reimbursed upon payment being received from your insurance company in the event that the payment is not made directly to you.

2. We file secondary insurance claims as a courtesy. If your secondary insurance has not paid within 60 days of our first filing, you automatically become responsible for the balance of unpaid charges.

I have read and understand "The Clinic for Neurology, P. A. Financial Policy." I agree to assign insurance benefits to The Clinic for Neurology, P. A. whenever applicable. In the event of non-payment of default, I am responsible for all cost of collections, including, but not limited to: collection agency fees, court cost and reasonable attorney fees. The Clinic for Neurology, P. A. reserves the right to change or amend this financial policy at any time and at their discretion.

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Signature of Patient/Responsible Party Printed Name of Signer

_____ _____

Patient Date of Birth Date