NEUROLOGY ASSOCIATES
Practice Financial Policy Statement

Thank you for choosing our practice for your health care needs. The following is a statement of our Financial Policy, which you must read, agreed to and sign, prior-to treatment. The policy applies to all service rendered by our staff whether inpatient or outpatient.

Patient Payment Policy Guidelines:
Patients or their guardians are financially responsible for all charges, regardless of third-party involvement. Full payment is due at time of services, unless prior insurance billing arrangements have been made. Patients with insurance will be required to pay all 'out-of-pocket' financial obligations at time of service. We accept: Cash, Check, Bank Debit Card, the following credit cards: Visa, MasterCard, and Discover.

Patient Responsibilities and Financial Policies:
Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive diagnostic and therapeutic services from our physicians. Patients are responsible for securing the necessary written Referrals, Pre-authorizations or Pre-certifications from your primary care physician or health plan prior-to rendering services. If we have not received the necessary authorizations prior-to your appointment, you will be required to sign a waiver acknowledging your financial responsibility for the encounter charges or the appointment will be rescheduled. Any coverage or payment dispute is a matter between the policyholder and the insurance company. Please present your Insurance ID card to our staff upon registration for each office visit.

Self-Pay Patients: Patients without insurance coverage are expected to pay for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior-to services being rendered.

Patient with Private Insurance / Medicare: Our physicians participate with the Medicare Programs and with most major insurance companies. We will file claim(s) to your insurance provided you authorize the 'assignment of benefits' below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we do not participate (i.e., Indemnity or 'Out-of-Network' plans), the practice will expect full payment from the patient at time of service or will balance bill the patient the full remaining balance after payment is received from insurance.

Patient Payment Agreement:
I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, coinsurance, co-payment, or services deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 60 days, the outstanding services will become my responsibility for immediate payment (unless Medicare). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason, I agree to pay all charges within 15 days of notice.

I understand that if I fail to pay outstanding balances or make payment arrangements within 60 days, the amount due will be considered delinquent and subject to legal action. I further understand that delinquent accounts will be assessed a 1.5% interest charge per month (18% APR), and the possible dismissal of the patient from our care. If my account is forced to 'collections', I agree to pay all collection costs, including, but not limited to, court costs, attorneys fees , and accrued interest charges to date.

I understand that if my check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $50.00.

I agree to pay a $50.00 fee for each missed appointment not cancelled at least 24-hours in advance. Copies of my medical records can be obtained with advanced notice in accordance with §8.01-413 of the Code of Virginia, with charges not to exceed $0.50 per page for the first 50 pages and $0.25 per page thereafter, in addition to a $35.00 handling fee plus postage expense. The completion of special forms or reports has a minimum charge of $25.00 for each form.

In consideration for medical service rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agree to the above policy.

_____	_____	_____
Signature of Patient or Responsible Party	Print Full Name / Relationship to Patient	Date