FINANCIAL POLICY FOR ASSOCIATES IN NEUROLOGY, P.C.

Associates in Neurology, P.C. is committed to providing you with the best possible medical care. Please understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this medical office for you, our patient. All appointments related to **WORKMAN'S COMPENSATION** or **PERSONAL INJURY** cases must have **PRIOR APPROVAL**. As a courtesy to you, we will file your insurance claims for you provided that your coverage is in effect at the time of service. Patients on Risk Based Managed Care Medicaid Programs are required to provide a referral from their Primary Physicians. If proper authorization is not obtained, your appointment will have to be rescheduled.

PLEASE REVIEW THE FOLLOWING INFORMATION:

* We accept Visa, MasterCard, Discover, cash, personal check, cashier's check and money order for payment.
* If a check is returned, a $30.00 charge will be assessed to your account. This fee and the amount of the returned check must be paid prior to your next appointment.
* All personal injury cases (i.e., workman's compensation/motor vehicle accident) will be considered self-pay or cash accounts unless we receive complete insurance information. We will file your work. comp./auto insurance claim if *prior approval* has been obtained and all information is accurate and complete.
* *Third party liability action against someone else is not a reason to delay payment. Payment of the bill is the responsibility of the individual who has received the treatment, not the individual who is being sued. Associates in Neurology, P.C. does not accept third party liability cases.*
* Payment arrangements must be made with our billing department on unpaid balances. Please contact the billing department for any questions at 219-476-7777, ext. 112 or ext. 114.
* ***We are contracted with several insurance companies and payment at the time of service will be determined by their rules which include copays, deductibles and any non-covered services. It is the patient's responsibility to check with their insurance company regarding pre-certification and medical coverage issues.***
* Secondary insurance is filed when adequate insurance information is provided to us.
* If you had services rendered at the hospital, it is your responsibility to provide our billing office with the appropriate insurance information.
* *IF YOU CANNOT MEET THESE CREDIT TERMS, PLEASE CONTACT OUR COLLECTION DEPARTMENT SO THAT ARRANGEMENTS CAN BE MADE.*

For any additional questions please contact our billing office at 219-476-7777, ext. 112 or ext. 114.

Respectfully,

Associates in Neurology, P.C. Billing Dept.

I request that payment of insurance benefits be made directly to Associates In Neurology, P.C. or its physicians for any services rendered to me. Regulations pertaining to medical assignment of benefits apply. I authorize Associates In Neurology, P.C. to release any medical information for the purpose of processing insurance claims in writing or verbally. I permit a copy of this authorization to be used in place of an original.

I have read and understand the Financial Policy of Associates In Neurology, P.C. I agree and understand that I am obligated to pay for all services rendered to me by the physicians of Associates in Neurology, P.C. I understand and agree that, in the event I do not pay for services rendered to me and my account becomes delinquent, I will be responsible for any costs including court, attorney or collection fees assessed in order to collect payment on my account.

PATIENT SIGNATURE ______________________ DATE ______________

RESPONSIBLE PARTY SIGNATURE (for patient under age 18) ______________________ DATE ______________

MEDICARE PATIENTS SIGN BELOW

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

PATIENT SIGNATURE ______________________ DATE ______________