

Signature on File
Medicare Part B

Name of Beneficiary: _____

Health Insurance Claim Number _____

I request that payment of authorized health insurance benefits, including Medicare and Medigap, be made either to me or on my behalf to Dr. _____ (Department of Neurology) for services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____

Signature on File
Commercial Insurance

I hereby authorize direct payment of surgical/medical benefits to Dr. _____, for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Dr. _____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Patient's Signature: _____ Date: _____

Department of Neurology

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. A PHOTOCOPY OF YOUR INSURANCE CARD(S) WILL BE MADE FOR YOUR FILE.

- **CO-PAYMENTS** - By law we MUST collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each visit.
- **NON CO-PAY PLANS** - If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.
- **REFERRALS** - If your plan requires a referral from your primary care physician it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, **YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER.** It is then your responsibility to provide us with the referral as soon as possible. **IF A REFERRAL CANNOT BE OBTAINED FROM YOUR PRIMARY CARE PHYSICIAN YOU WILL BE RESPONSIBLE FOR THE FULL CHARGES FOR THE SERVICES PROVIDED.**
- **SELF PAY PATIENTS** - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier, who will reimburse you directly
- **MEDICARE** - We submit all Medicare claims. Patients are responsible for the deductible and the 20% co-insurance. Secondary insurance may reimburse for your Medigap deductible and co-insurance.
- **USUAL AND CUSTOMARY** - Is a term developed by the insurance carrier to reflect average charges from specific physicians in designated geographic localities. The usual and customary amount noted on the explanation of benefits does not accurately reflect individual physician charges. Therefore the usual and customary amount does not supersede the physician's charge.

You are responsible for the timely payment of your account.

WE ACCEPT CASH, CHECKS, MASTERCARD, AMERICAN EXPRESS OR VISA.

THANK YOU for taking the time to review our policies. Please feel free to ask questions or share with us special concerns.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

PATIENT COPY