Garden State NEUROLOGY & NEURO-ONCOLOGY, PC

NEUROLOGY | NEURO-ONCOLOGY | MOVEMENT DISORDERS | MULTIPLE SCLEROSIS | STROKE | EPILEPSY | HEADACHE | EEG | EMG

Name: _____ **Date of Birth:** _____

We are dedicated to providing our patients with the best possible care and service, while keeping the cost to you form rising at unreasonable rates. We ask for your help by understanding and cooperating with our **FINANCIAL POLICY**.

- **INSURANCES:** We participate with several insurance companies. It is your responsibility to call your insurance company to verify that the doctors in our practice are participating.

- **IF WE DO PARTICIPATE WITH YOUR INSURANCE COMPANY**, all services performed in our office will be submitted to them, unless we have prior notification of non-covered services. ALL COPAYS are the patient's responsibility and will be collected by our office at the time of service. Any deductible will be billed to the PATIENT/GUARANTOR for payment.

- **IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY**, we will help you submit your claim to your insurance company. All insurance carriers have a schedule of fees from which they will pay; however, the doctor's fee may be more than what the insurance shows on their schedule. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient/guarantor**. PAYMENT FOR AN OFFICE VISIT IS DUE AT THE TIME OF SERVICE.**

- IT IS IMPORANT FOR YOU TO UNDERSTAND THAT YOUR **HEALTH INSURANCE COVERAGE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY**. YOUR DOCTOR'S BILL FOR THE SERVICES PROVIDED TO YOU IS AN **AGREEMENT BETWEEN YOU AND YOUR DOCTOR.**

- PAYMENT FOR SERVICES: All payments are expected at the time of service and any outstanding balances are due IN FULL within thirty days, unless prior arrangements have been made with our office's billing department. All balances that reach 90 days past due may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

- If you belong to a HMO that requires a referral, please present it to our receptionist upon arrival. Referrals are YOUR responsibility to obtain and should be done so through PRIMARY CARE PHYSICIAN. If you do not have the required referral for your visit with the doctor or for a test you might be having, payment will be required at the time of your visit.

- If insurance is filed on my behalf, I hereby assign benefits directly to GARDEN STATE NEUROLOGY AND NEURO-ONCOLOGY, PC. I understand that I am responsible for my co-payment and any deductible that might not be covered by my insurance carrier. I also acknowledge that I have been given a copy of the office policies for GARDEN STATE NEUROLOGY AND NEURO-ONCOLOGY, PC.

- **ACCEPTANCE OF RESPONSIBILITY:** If the services provided to me, or the patient's named herein are not covered by the insurance carrier(s) listed, I agree that I am responsible for payment of these services.

- **ASSIGMENT OF BENEFITS:** I hereby authorize Medicare or other insurance carrier(s) providing me or the patient insurance coverage for which either I or the patient is eligible, to make payment on my or the patient's behalf, directly to GARDEN STATE NEUROLOGY AND NEURO-ONCOLOGY, PC for services rendered and provided either to me or the patient.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY GARDEN STATE NEUROLOGY AND NEURO-ONCOLOGY, PC AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

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SIGNATURE OF PATIENT/GUARANTOR **DATE**