Midtown Neurology Financial Policy

Self Pay
-Payment is due on the date of service if you are not covered by medical insurance.

Insurance
We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and Deductibles and Non-Covered Services:
*All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.
*Please help us in upholding the law by paying your co-payment at each visit.
*Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Forms of Payment:
*We accept cash, checks, and all major credit cards (Visa, MasterCard, American Express, and Discover).
*We accept credit card payments over the phone and also have the ability to send you a bill electronically to pay with your credit card over the internet.
*We also offer a line of credit through our billing partner, CareCredit®. Interest-free payment plans are available for those who qualify.
*There will be a $35 fee for returned checks.

Medicare
*Medicare requires 20% of their allowed fee to be paid by the patient or by a supplemental policy.
*A deductible is also required by most Medicare policies.
*If you do not have a supplemental policy, you will be billed for the 20% not covered by Medicare as well as your deductible.

Referrals and Prior Authorizations:
*If your insurance requires a referral from your primary care physician or prior authorization for services, you are responsible to inform us and obtain this information.
*We will assist you with this process when possible.
*We will be happy to reschedule your visit if the insurance requirements have not been met.
*If you do not have prior approval, you may still see the doctor if you pay your visit in advance.

Workman's Compensation:
*All workers compensation companies require prior authorization. You cannot be seen until prior approval is obtained. **If you "no-show" for an appointment, you will be discharged from our practice.**

No-Show Policy
*Established Patients: Midtown Neurology, P.C. reserves the right to charge a $50 fee for a missed appointment and $75 for a missed procedure. We may require you to pay this fee prior to your next appointment.
*Workers Comp Patients: **If you fail to show up for your appointment and do not call ahead of time to cancel, you will be discharged from our practice**
*New Patients: Midtown Neurology, P.C. reserves the right to charge a $50 fee for a missed appointment and $75 for a missed procedure. Please pay this when you arrive at your rescheduled appointment.

Cancellations:
*Call us if you cannot keep your appointment.
*No fee will be charged for cancellations 24+ hours prior to appointments and 48+ hours prior to procedures.
*If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. If a balance remains unpaid, we may refer your account to a collection agency and you will be responsible for collection and attorney fees.
*Additionally, you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Fees for Forms:
*There is a $50 fee for each form that you request one of our providers to complete.
*Fees must be paid in advance.
*Please allow up to 1 week for the completion of forms.

I have read and understand this financial policy. I clearly understand that it is my responsibility to pay my bill in a reasonable time. If for any reason any portion of my bill is not paid by my medical insurance, I hereby agree to make immediate payment in full or to make arrangements for prompt payment. I further agree to pay all reasonable costs of collection including attorney fees, if any.

Signature: ______________________ Print Name: ______________________ Date: ________