ACKNOWLEDGMENT OF FINANCIAL RESPOSIBILITY

INSURANCE CHANGES: If you have had any changes in your insurance coverage, please notify us immediately. Failure to do so may result in a claim denial and you will be billed.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES:
***Co-Insurance** and co-payments are the patient's/guarantor's responsibility.
***Co-payments** are due at the time of the visit, *along with any outstanding balances.*
***Deductibles** are the patient's/guarantor's responsibility. The deductible is determined by your health insurance carrier.

REFERRALS:
-If your plan requires, it is your responsibility to obtain referrals from your Primary Physician prior to visit. If you wish to be seen without the referral, payment is due at the time of visit.

INSURANCE REQUESTS:
-You are responsible for responding to insurance company requests for further information. We can not speak on your behalf as we are not the patient.

INSURANCE PAYMENTS:
-Any Insurance payments sent to you should be forwarded to our Billing Office with a copy of the explanation of benefits (EOB) received. If not received and the insurance has advised our office that a payment was made to the patient, you will be billed and responsible for the payment.

CANCELLATION/NO SHOW
-Cancel or reschedule your appointment at least 48 hours prior to your appointment. When a patient does not cancel or reschedule within 48 hours the following fees will be billed:

No Shows and Cancellations less than 48 Hours of your appointment.

$100.00 for Evaluations

$50.00 for Follow-up's

$100.00 for TESTING (EEG, EMG, TCD, etc)

_____ I have been informed of the fees above and agree to pay.

Print Patient Name_____

Signature _____ Date_____