

SOUTH FLORIDA NEUROLOGY ASSOCIATES, P.A.
1601 CLINT MOORE ROAD, SUITE 120, BOCA RATON, FL 33487
PH: 561-939-0300 FAX: 561-939-0339

FINANCIAL AGREEMENT FORM

We, the staff of **South Florida Neurology Associates, PA** thank you for choosing us as your medical provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact Mishelle Mostun at 561.939.0300 x 6308.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. **If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.**

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, and in-state checks). A \$35.00 service fee will be charged for all returned checks.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

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Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Medicare

We are Medicare providers and therefore we accept the Medicare allowable for covered services. We are NOT, however, necessarily on any other Medicare “advantage” or HMO plans. You will be responsible to pay the deductible (if it has not already been met for the year) AND the 20% Medicare co-payment if you do not have a secondary insurance.

Auto Insurance

We will need a copy of your medical insurance card(s) even if you are covered under an auto claim. Any remaining balance will be billed to your health insurance (only those we participate with) once your auto insurance benefits have been exhausted. Be advised that if we are a non-participating provider with your health insurance, you will be required to pay the entire balance and file a claim to seek reimbursement. ***Note that it is in your best interest to stay within your health insurance network for best coverage. Contact your insurance company to find a provider in your network.*

Workers Compensation

Our office does **NOT** work with Workers Compensation.

Participating Insurance Plans

If our office participates with your insurance plan, you will be expected to pay your deductible and co-payment at the time services are provided. Call your insurance company to see if we are on their participating panel.

Non-Participating Insurance Plans

You will be expected to pay in full for your services at the time of the visit. **Please be advised that we are not obligated to take any contractual adjustments and you will be responsible for all charges at the time of service.** Testing orders will be given to you in prescription form to take to your participating primary care physician so arrangements can be made so the services can be covered in your network. If you choose to have the testing done in our office, you will be required to pay at the time of service and you can request an itemized bill to file your own insurance claim.

Miscellaneous Forms, Additional Information, and Authorizations

We will provide all necessary information to have your benefits released.

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Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee can be applied. These fees are typically \$25.00. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: _____

Date: _____