SOUTH FLORIDA NEUROLOGY ASSOCIATES, P.A.
1601 Clint Moore Road, Suite 120
Boca Raton, FL 33487
Phone: (561) 939-0300 Fax: (561) 939-0339

INSURANCE and PAYMENT POLICIES

Please read the following carefully so that you are aware of our office policy regarding insurance and financial responsibility and/or payment requirements.

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.**

SECONDARY INSURANCE

We are not able to file secondary insurance claims. Medicare usually forwards the claims to your secondary insurance.

AUTO

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 for 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.

I have read and agree to the terms of South Florida Neurology Associates, P.A office policy regarding insurances and my financial responsibilities. I further understand that my financial responsibility will include all collection and/or legal fees resulting in non-payment of my account.

Patient Signature_____ **Date**_____