

# Billing Policy

The following sets forth the general billing policy of Neurological Associates of Nevada. Please review this information and sign where indicated.

- ❖ I understand that it is my responsibility to provide the office of Neurological Associates of Nevada with current, accurate billing information at the time of check in and to notify NAN of any changes in this information.
- ❖ I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- ❖ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- ❖ I understand that there is a \$20 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms (such as FMLA) require completion, I understand that the \$20 fee (payable prior to completion) is required.
- ❖ I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any medical treatment that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my medical treatment. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated procedures to be performed and 2) current information provided to clinic by my insurance carrier.
- ❖ I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- ❖ I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- ❖ I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

**My signature below confirms that I have read and understand these billing policies and my financial obligation, as well as the HIPPA policies and procedures notice I received, as it pertains to the office and physicians of Neurological Associates of Nevada.**

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Legal Signature

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Date

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Relationship to Patient