**OUR FINANCIAL POLICY**

NEUROLOGY ASSOCIATES OF SUFFOLK

Thank you for selecting Neurology Associates of Suffolk, PLLC (NAOS) as your health care provider.

In an effort to keep your patient information as current as possible, we ask that you present your insurance card at each visit and notify us as soon as possible of any changes in your insurance coverage, address and/or telephone numbers. Co-Payments and Deductibles are due at the time of service. We accept Cash, Checks or Credit Card.

**PARTICIPATION**
Our physicians participate with most HMO's, PPO's and other health insurance plans. Each insurance plan has unique rules and regulations that must be followed by patients and physicians. Please familiarize yourself with the particular benefits and rules of your healthcare plan.

**NON-PARTICIPATION**
If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full at time of service. In the event your insurance company pays our office directly, we will refund the payment to you as soon as possible.

**REFERRALS**
Certain health insurance plans require that you obtain a referral from your Primary Care Physician before visiting a specialist's office. It is the patient's responsibility to acquire this referral. Alternative payment arrangements or rescheduling of your appointment may be necessary if proper authorization is not obtained.

**WORKERS COMPENSATION**
We require approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full. If you have health insurance, we request that you provide us with the information and a copy of your insurance card in the event that workers compensation denies your claim.

**SELF PAY**
Payment in full is expected at time of service.

**RETURNED CHECK FEE**
We charge a $25.00 fee for all returned checks.

**NO SHOW CANCELLATION POLICY**
A no-show cancellation policy has been established to ensure all patients timely and efficient availability to our providers. We reserve the right to charge our patients a $25.00 charge for failure to attend an appointment without contacting our office in advance to cancel or reschedule your appointment. Your insurance company will not be held responsible for this charge.

Please let us know if you have any questions or concerns by contacting our business office Monday-Friday at (757) 934-1900 between 8:00 am-4:30 pm.

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**FINANCIAL AGREEMENT**

I have read, understand and agree to this financial policy. I understand that I am financially responsible for all charges incurred by me for services rendered by Neurology Associates of Suffolk, PLLC, whether or not these services are covered by insurance, including all costs incurred to collect delinquent charges, as well as collection agency and attorney's fees of 33 1/3%.

_____ _____
Signature of Patient/Guarantor Date

**ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL RECORDS**

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Neurology Associates of Suffolk, PLLC.

_____ _____
Signature of Patient/Guarantor Date