

**NEUROFEEDBACK PROGRAM**

**PATIENT FINANCIAL RESPONSIBILITY AGREEMENT**

Thank you for choosing Neurological Specialists, P.C. as your healthcare provider. The Neurofeedback Program (“Services”) you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the Services that you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. By signing below and/or by receiving medical Services from Neurological Specialists, P.C. (“Neurological Specialists”), you agree to the following:

1. The Services consist of the following:
   1. Quantitative Electroencephalogram/ Electroencephalography (“QEEG”). This study will be billed to your insurance carrier, subject to the terms and limitation set forth herein;

* 1. Following the QEEG, you will have a consultation appointment with a qualified physician. This consultation will NOT be billed to your insurance carrier. This consultation shall be billed as private pay in the sum of **Five Hundred Dollars ($500.00)**; and
  2. Following the consultation appointment *if you are eligible to start the neurofeedback session*, you will attend at least twenty (20) but not more than forty (40) Neurofeedback sessions at our office. Each session will be billed to your insurance carrier. In addition, for each session, you will be billed as private pay the sum of **One Hundred Dollars ($100.00)**.

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier.
2. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount your visit may be re-scheduled by Neurological Specialists.
3. We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign Neurological Specialists, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of services provided to you. You authorize Neurological Specialists to and associated physicians, staff and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports, or other documents related to your treatment (including itemization of any charges and payments on the account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they required to participate in your case. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Neurological Specialists does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefits plans.
4. If your insurance carrier does not remit timely payment on your claim, the office will assist in appealing the claim, though you will be responsible for payment of the charges based on our contract with the payor.  Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Neurological Specialists until your patient account is paid in full.
5. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the Patient Accounts Staff to address the problem or to discuss a workable solution.
6. Whether or not you have insurance or are self-pay, payment of any account balance is due at ourBilling Office within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and auto referred to a collection agency.
7. We accept payment by check, cash, money order, debit cards or credit cards (Visa, MasterCard). We also accept payment from a “Health Savings Account” (HSA) for qualifying out-of-pocket or self pay expense(s).
8. **Managed Care (HMO, PPO, etc.).** All managed care co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician, you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as “out of network” or “non-covered” treatment, and you will be responsible for a larger amount or all of the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.
9. **Non-payment on Account**. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Neurological Specialists has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care.

**ACKNOWLEDGEMENT**

By signing below, I acknowledge that: (i) I have been provided a copy of the Neurological Specialists, PC, PATIENT FINANCIAL RESPONSIBILITY AGREEMENT; (ii) I have read, understand, and agree to the provisions and specified terms contained herein; (iii) I agree to pay all charges due (or to become due) to Neurological Specialists for the care and treatment I receive as described herein, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys’ fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Agreement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (“.PDF”) SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Responsibility Party/Guardian Date

Waiver of Patient Authorization

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Responsible Party/Guardian Date