Pediatric Neurologists of Palm Beach

Patient Financial Agreement

We would like to take this opportunity to Thank-you for choosing Pediatric Neurologists of Palm Beach to provide your child's neurological care.

In an effort to try to contain the rising cost of healthcare, we have implemented this financial policy for you to review and sign. You may request a copy for your records and the original will be scanned to your chart.

INSURANCE BENEFITS AND COVERAGE

As a courtesy to you, our billing company will submit your insurance claim(s) for treatment rendered in the office. Please understand that your insurance policy is a contract between you and your insurance company. It is your responsibility to contact your insurance company to review your coverage and benefits. Ultimately, you are responsible for all costs incurred during the treatment with the exception of insurance payment adjustments. These adjustments are determined by the contract between the physician and the insurance company. If your insurance does not accept assignment of benefits and pays you directly, that payment must be made in full to us at the time of visit.

COPAYMENTS, DEDUCTIBLES AND COINSURANCE

Our office requires payment of any copayments at the time of service. In addition, if it is determined that you have a deductible or coinsurance, that will be also be collected at time of visit. The verification process does not always reveal this information. In that case, any deductible or co insurance amounts to be met will be billed to you once your insurance company has processed their portion of the claim and sent the Explanation of Benefits or EOB. While we make every effort to inform you of anticipated patient financial responsibility in advance, verification of benefits is not a guarantee of the amount you will owe. It is your responsibility to call your insurance company to determine this. Acceptable payment forms are cash, credit or debit.

UNINSURED PATIENTS AND NON-COVERED BENEFITS

Full payment is due at the time of service. In some instances a payment plan may be arranged on a case by case basis with our office. While we try to accommodate all of our patients, our office maintains strict guidelines regarding payment plans.

BALANCE AND STATEMENTS

You will receive a statement once a month if you have a balance. Failure to pay the balance by the 4th consecutive statement will result in your account being turned over to a collections company. The same would apply to patients with a payment agreement. Please be aware this can affect your credit rating. Also note there is a $50 NSF returned check fee.

REFERRALS

Referrals are required at time of visit. If a referral is required by your insurance company, please make sure to present it at your appointment. Failure to do so will result in your appointment being rescheduled. It is your responsibility to obtain the proper referral required by your insurance carrier

We are dedicated to providing your family with the highest level of neurological care. We will make every attempt to accommodate our patients whenever possible. If you have any questions or concerns, please contact our office manager and we will be happy to discuss them with you. Thank-you for your understanding.

Signature of parent/responsible party **Date** **Rev 1/2018**