Center for NEUROSCIENCES

PATIENT AGREEMENT OF FINANCIAL RESPONSIBILITY

This is a summary of the CNS financial policy. **Patients are required to read and agree to these terms prior to treatment by CNS, as a condition to receipt of CNS treatment.**

1. Physician/clinician charges for medical and related professional services performed or supervised by a CNS physician/clinician, will be billed separately from hospital charges.

2. I understand that actual charges might be different from estimates of charges.

3. I am responsible for understanding my insurance benefits and pre-authorization requirements. I will provide current, accurate and updated insurance information, insurance card, and government issued identification, to CNS. CNS will bill my insurance company, but if my insurance denies payment, or does not pay the full billed charge, I am responsible for full and prompt payment of all unpaid amounts and non-covered or balance/amount not paid by my insurance. If CNS is out-of-network of my insurance company, I will submit a claim for reimbursement to my insurance company. CNS is not responsible for billing out-of-network insurers. Although CNS participates in many insurance plans including Medicare, continuation in participation in insurance plans, might change, and it is not guaranteed. I am responsible for knowing whether my insurance benefits are accepted, and I will pay for all charges not covered by my insurance.

4. I will pay applicable interest charges and late fees. Charges/accounts that are more than 60 days past due, will be charged interest at 10% per year, or the maximum rate as allowed by law. Interest will be compounded monthly on the balance that is not determined to be the responsibility of my insurer. If I do not have health insurance, or if I have not provided current or accurate insurance information, I am responsible for payment of all charges and fees. Returned/declined checks and credit card reversals will be charged applicable returned check and credit card reversal fees. Future visits may require payment via a cashier's check, money order, or cash.

5. I will pay all applicable copayments, deductibles, coinsurance, and non-covered charges. Co-payments and charges not paid by insurance are due at the time of service. CNS will not waive deductibles, copays, or coinsurance amounts.

6. I assume full financial responsibility, and will ensure payment of all charges in full. Delinquent charges may be referred to a collection agency. I agree to pay all fees and costs associated with collection of unpaid balances. Collection agencies commonly charge a minimum fee of 35%, plus attorney and other expenses.

7. If the patient is a minor, then I as the parent or legal guardian am responsible for payment.

8. Medicare/Medicaid/AHCCCS/Insurance Certification, Assignment**.** I have been informed and understand that Medicare will only pay for services that it determines to be reasonable and necessary.

9. I certify that the information I have provided in applying for payment for my health care under the Medicare or Medicaid/AHCCCS programs is correct.

10. I authorize assignment of payment and financial benefits by Medicare/Medicaid/AHCCCS/ Insurance company/or other payor, be made directly to the Center for Neurosciences or its designated

affiliated entity, on my behalf. I authorize the Center for Neurosciences to bill directly and I assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the Center for Neurosciences.

11. I will provide notice to CNS prior to treatment, if my condition was caused due to a Workers' Compensation (WC) injury. I will provide the necessary and complete information to bill WC. If my WC claim is denied, then my medical insurance will be billed. I will immediately pay any amount not covered by insurance.

12. I will provide notice to CNS, prior to treatment, if my condition was caused by a third party (i.e. car accident, slip and fall, etc.). Payment will be due when services are provided. CNS will not accept attorney letters, contingency payments or assignment of third party payment from an attorney or other party.

13. MRI Studies: You may be subject to a $50 "no-show" fee for missing any scheduled MRI appointments at CNS. Please provide at least one business day notice before canceling or rescheduling any Imaging appointment. "No show" fees are billed directly to the patient and are not covered by insurance.

14. Completion of Forms: If applicable you may be charged $25 for the completion of any FMLA or Disability paperwork. This one-time payment is good for all form completion requests for a period of one year.

15. **I have read and understand this Agreement. I guarantee full and prompt payment of all debt owed to CNS and I will pay any and all expenses/fees arising from enforcement of this Agreement.**

Please ask to speak with a staff member if you have any questions.