

## **Meadowbrook Neurology Group, P.C.**

### **Financial Policy**

Thank you for choosing Meadowbrook Neurology Group, P.C. (MNG) as your care provider. We firmly believe that a good physician/patient relationship is essential to good care and is based upon understanding and effective communication. We are committed to providing you with the best possible medical care. The following is our financial policy: You must read and sign this agreement before your treatment will begin. A copy will be provided upon request.

**Insurance.** Our office participates with a variety of insurance plans. It is your responsibility to:

- **Provide proof of your health insurance coverage.** Bring your insurance card to every visit and notify us of any changes in coverage.
- **Know your co-payment amount and be prepared to pay this amount at each visit.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. We will assess a service fee of \$10 if we must bill for a co-payment.
- **Know your insurance company benefits (physical exam coverage, diagnostic testing co-payment amounts and pre-certification requirements, etc.)**
- **Provide any referrals needed.** If you are enrolled in a managed care insurance plan (HMO) it is YOUR responsibility to obtain or ensure a referral is supplied to our office from your primary care physician prior to the time of your appointment. Without this referral, you will not be seen by our physicians.

If you have insurance coverage through a plan with which we do not participate, we are happy to file the claim for you as a courtesy. However, you are responsible for payment in full at the time of service. You will be reimbursed upon payment being received from your insurance company, in the event that the payment is not made directly to you.

We file secondary insurance claims as a courtesy. If your secondary insurance has not paid within 60 days of our first filing, you automatically become responsible for the balance of unpaid charges.

**Non-covered services.** If your insurance company determines that the services you receive are not covered, you may be responsible to pay for them. Please contact your insurance company with any questions you may have regarding your coverage.

**Payment.** All co-payments, coinsurance and deductibles are due and payable at the time of service, regardless of who brings the patient in for the appointment. Sitters, grandparents, divorced parents, etc., must be prepared to pay at the time of service. MNG accepts cash, checks, debit cards, Discover, MasterCard, and VISA.

**Returned Checks.** Our bank charges us for all returned checks and we pass that charge on to you. There is a \$50 service charge for returned checks. After receiving two returned checks, payment will be required in cash or via credit card.

**Nonpayment.** If your account is over 90 days past due, we may refer your account to a collection agency and you will be required to pay the entire amount plus any collection agency fees before being scheduled for any further appointments. If the balance remains unpaid and you do not contact us to make payment arrangements, you may be terminated from the practice. If you need financial assistance or have questions, please contact our Billing Department at (215) 938-9604.

**Overpayments.** Overpayments will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed to the patient or guarantor within 30 days of an overpayment. In some instances, we are not immediately aware of an overpayment. Please contact our office if you are aware that an overpayment has been made.

**Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**Missed appointments.** When you schedule an appointment with us, we reserve that time especially for you. If you fail to appear for your appointment and do not cancel, we are unable to offer that time to another patient. We reserve the right to charge \$50.00 for missed appointments not canceled within 24 hours of the appointment time. These charges will be your responsibility and are not billed to your insurance company. Please help us to serve you better by keeping your regularly scheduled appointment. Patients who “no-show” more than once may be terminated from the practice.

**Forms**

Completion of forms represents a significant cost to the practice. Insurance companies do not pay for this service. We charge for the completion of forms including driver license forms, life insurance forms and work disability forms that require significant time and effort to complete.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

\_\_\_\_\_  
**Signature of patient or responsible party**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Signer**