AUSTIN
NEUROMUSCULAR
CENTER

FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions about this form, please discuss it with one of our front office employees. We are dedicated to providing you the best possible care and regard your complete understanding of our financial policies as an essential element of your treatment.

- Payment is due at the time of service unless other arrangements were made in advance. For your convenience we accept cash, check, and most major credit cards. Payments can also be made in advance through your patient portal account.

- Your insurance is an agreement between you and your insurance carrier(s). As a courtesy to you we will file your insurance claims for you if you assign benefits to the physician. Your signature below authorizes the release of pertinent medical information to your insurance carrier(s). If your insurance carrier(s) do not pay within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment directly back to you.

- We have made prior arrangements with many health plans to accept assignment of benefits. If you are covered by one of these plans, we will bill your plan and will only require you to pay the copayment, deductible, and/or co-insurance due at the time of service. Your signature below indicates you are assigning your insurance benefits to be paid directly to Austin Neuromuscular Center, Yessar Hussain, MD, PA; for services rendered.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you READ YOUR INSURANCE POLICY BOOKLET or a copy of the contract your policy falls under to determine your benefits.

- You will be responsible for promptly responding to your insurance carrier to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents, or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable by you in full immediately.

- If your insurance policy requires a pre-authorization or primary care referral, it is your responsibility to make sure that we have one on file at least one week before your appointment in our office. Due to restraints of the size of our clinic we will fax your primary care physician's office requesting this <u>one time only.</u> It is your responsibility to keep an up-to-date referral with our office during your continuing care.

- A prepayment of your deductible and coinsurance will be required for your portion of our fees, based on your contract allowable. Any balance remaining after your health plan pays its portion is your responsibility and payment for this balance is due upon receipt of a statement from our office.

- Be prepared to present your insurance card and proof of identity (ex – driver's license) at each visit. You will be responsible for providing a change of address, phone numbers and/or insurance information any time a change occurs.

- <u>CANCELLATION POLICY:</u> **We enforce a $100 fee for appointments and $250 fee for procedures that are not cancelled or rescheduled at least two business days prior to the scheduled appointment/procedure.** As a courtesy our office contacts you to remind/confirm future appointments however this is only a courtesy, and it is the patient's responsibility to keep track of appointments made and to contact our office within the timeframe listed here if they need to be changed. Payment for such fees is due upon receipt of a statement from our office.

- Self-Pay Patients: if you (1) do not have insurance coverage (2) choose not to use your insurance coverage, or (3) are seeking treatment/services that are not covered by your insurance plan you are a 'self-pay' patient. A 30% discount of our regular fees will be applied toward all charges and payment will be required at the time of service. Alternate payment plans are available at the discretion of our practice manager (30% discount may be forfeit).

***continue to next page for acknowledgement and signature.**

I have read and understand the financial policy outlined above, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by Austin Neuromuscular Center.

Patient name: _____

Signature: _____

Date: _____

If other than patient, relationship to patient (for minors):

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