AUSTIN NEUROMUSCULAR CENTER

FINANCIAL POLICY

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

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

2 A payment will be required for your portion of our fees, based on your contract allowable rates, deductible, and coinsurance. You will receive this estimated amount due prior to your visit. Payments can be made in advance through the link you will receive otherwise they will be collected at check in.

3 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 and must be paid prior to your next visit.

4 When scheduling your initial visit or rescheduling in the case of established patients, we will request the patient or patient's guardian/guarantor for a credit card, which may be used later to pay any balance that may be due on your bill. Please see the Credit Card on File Agreement for more information.

5 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.

6 We have made prior arrangements with many health plans to accept the 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 estimated 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 for services rendered.

7 Not all health plans are the same and do not cover the same services. If 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.

8 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

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insurance coverage. Failure to respond promptly may result in your account becoming due and payable by you in full immediately.

9 If your insurance policy requires a pre-authorization or primary care referral, you must ensure that we have one on file at least one week before your appointment in our office. We will fax your primary care physician's office requesting this one time only. You are responsible for keeping an up-to-date referral with our office during your continuing care. Your appointment will be rescheduled if we do not have a current referral on file.

10 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.

11 CANCELLATION POLICY: **We enforce a $100 fee for appointments that are not canceled or rescheduled at least two business days before 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 will be collected from the credit card on file.

12 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 on our regular fees will be applied to all charges, and payment will be required during service. Alternate payment plans are available at the discretion of our practice manager (a 30% discount may be forfeited).

I have read and understand the ANC 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 the patient, please state the relationship to the patient (for minors):

_____

p : (512) 920-0140 | f : (512) 920-0142
www.austinneuromuscle.com

4705 Spicewood Springs Rd.
Austin, TX 78759