

Welcome to Southeast Neuroscience Center

We are pleased that you have chosen *Southeast Neuroscience Center* to address your neurological needs. We are committed to an effective physician/patient relationship. That is why it is important that you read, understand and sign the office policy below.

OFFICE POLICY

You should be aware that the payment for services rendered is your responsibility. All payments are due at the time services are rendered unless other arrangements have been previously discussed with the financial representative. You must understand and agree to by signing below that you authorize payment of medical benefits from your insurance company or other designated agency to Southeast Neuroscience Center. You must also be aware that if the projected payment is not received from your insurance company or other designated agency within 45 days, the balance will automatically be considered your responsibility.

Southeast Neuroscience Center does not bill to your personal medical insurance for motor vehicle or work related injuries. You must provide the appropriate auto insurance or workers compensation information for pre-approval prior to the time of visit. If the proper information is not provided you will be responsible for payment of your visit.

If you have legal representation in regards to injuries being evaluated by one of our physicians, Southeast Neuroscience Center will not bill your personal insurance. Payment must come from your attorney. Each visit must be paid before or at the time of the visit. We do not accept payment out of settlement

You should be aware that should your account become delinquent and your account is sent to a collection agency, you will be responsible for all costs of collection including but not limited to agency fees, court costs, and any interest which may accrue.

Southeast Neuroscience Center reserves the right to charge a **\$35.00** charge for **NSF checks**.

Requests for **prescription refills** should be called in when you have **three (3) days of medication remaining**. **Written prescriptions** should be requested when you have **seven (7) days remaining**. Failure to follow this policy can result in you running out of medications unnecessarily.

Southeast Neuroscience Center requires **24 hour notification** for missed and/or cancelled appointments. Failure to do so may result in a cancellation fee that is due and payable before any further appointments will be made.

There are times when you may require that we complete a form for work or other related issues. Our **form fee is \$5.00 a page** that is **not** billable to your insurance company. This fee must be paid by the patient at the time the form is brought to Southeast Neuroscience Center.

There may be times when our staff may need to have verbal correspondence with another person in regards to your healthcare. Who can we speak with about your treatment and/or billing if you are unavailable?

Name of approved contact person(s) _____

Thank you for taking the time to read our policy. Please let us know if you have any questions.

I, _____, have read and understand the above office policy.

Print Patient Name

Signature of Patient or Responsible Party

Date