NEUROLOGY OFFICE

JOSEPH KANDEL, M.D.

& ASSOCIATES

PATIENT FINANCIAL POLICY

As health care providers we are committed to providing our patients with the best medical care possible. As a business, we are committed to providing a streamlined fiscal process that allows our patients to clearly understand their financial responsibility.

Identification

- Proper identification must be presented prior to service being rendered.
- Current insurance cards must be presented prior to service being rendered.

Commercial Health Insurance

- Insurance companies require that co-payments are collected prior to service.
- New co-insurance or deductible amounts will be billed after the date of service.
- These amounts can only be calculated after your appointment.
- Neurology Office does not contract with every insurance company.
- Patients are responsible for asking if Neurology Office participates with their insurance.

Medicare

- Neurology Office will submit claims to Medicare, however you may need to sign an ABN form for non-covered services.

Worker's Compensation

- Patients are financially responsible for medical services related to Worker's Comp if insurance does not pay.
- Patients will supply WC contact information prior to services being rendered.

Motor Vehicle/Third Party Liability

- Patients are financially responsible for medical services related to motor vehicle accidents.
- Patients shall supply auto insurance, third party and/or attorney information.

Self Pay

- Self-pay accounts exist if patients have no insurance coverage.
- Payment is expected in full at time of visit.

Statements/Payments

- Statements are sent to patients on a monthly basis showing outstanding balances.
- Patient is responsible for balances not paid by insurance.
- We accept all major credit cards, checks, money orders and cash.
- A fee of $25 will be charged for all returned checks.

I hereby assign, to Neurology Office, Joseph Kandel MD & Associates, payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether or not they are covered by my insurance policy, as well as any co-payments, or co-insurance.

Printed Name: _____

Signature: _____

Date: _____