AUSTIN NEUROLOGICAL CLINIC

OFFICE: 711 WEST 38TH STREET, BLDG. F, AUSTIN, TEXAS 78705
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NEUROLOGISTS

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Date: _____

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In anticipation of your visit to our clinic, enclosed are the following for your review:

1. Map to our office
2. Patient Registration Information
3. Health History Questionnaire
4. Notice of Privacy Policies with Acknowledgement
5. Clinic Financial Policies (blue)

Please complete the Patient Registration Information and Health History Questionnaire before you come into the office for your appointment. It will help with getting you in to see the doctor more quickly.

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to inform you of our policies around protecting your personal health information. The Notice of Privacy Policies explains our policies and your individual rights as a patient of this clinic. We ask that you read this Notice before your appointment time. You will be asked to sign an acknowledgment form that you have read the policies when you come to the clinic for your appointment. Again, by reading the policy in advance, there will be less delay in seeing the doctor.

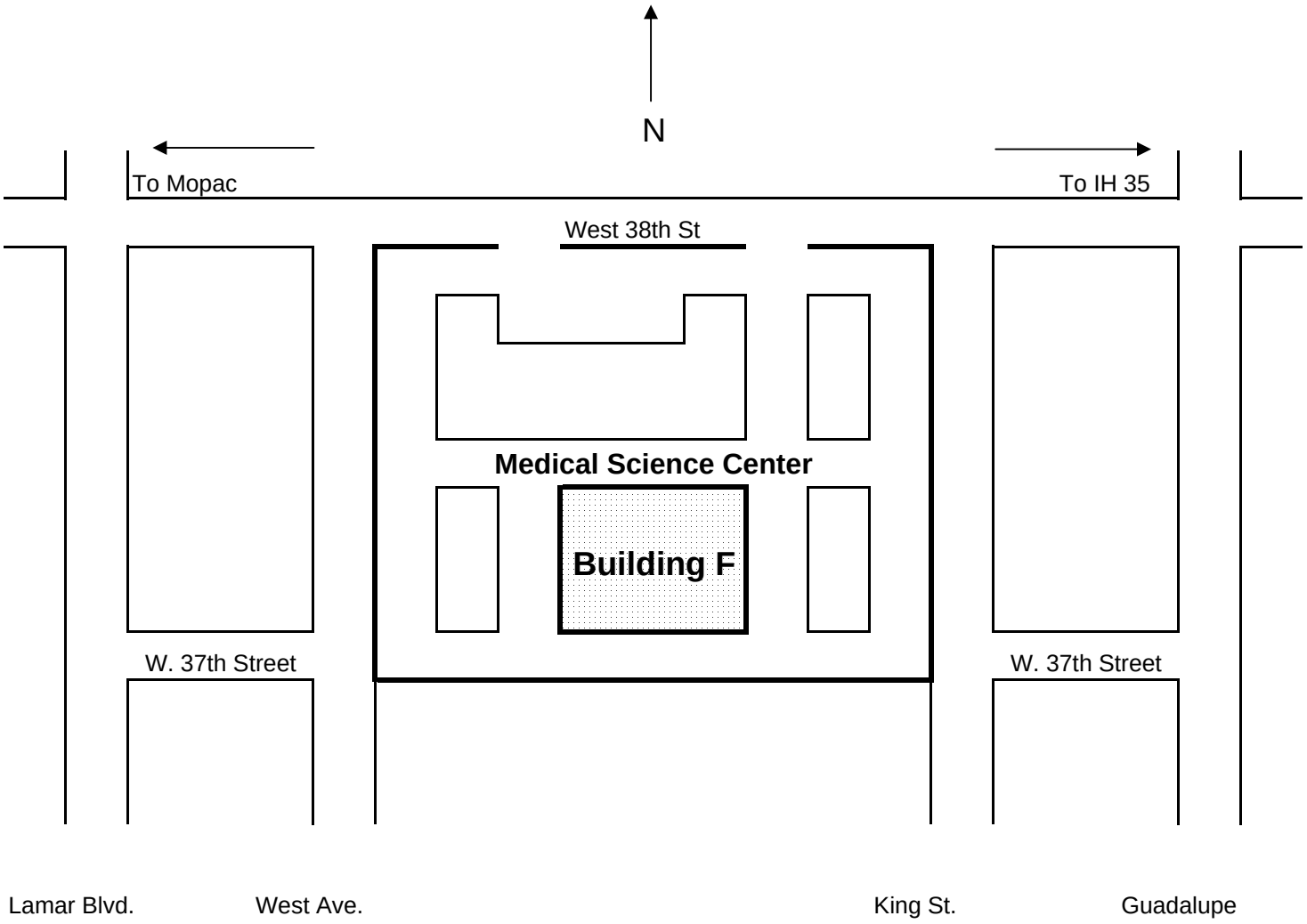
Finally we have included our financial policies regarding payment of your bill and filing of insurance claims. This form will need to be signed as well.

We apologize for the amount of paperwork involved in seeing our doctors, however we find it necessary to comply with regulatory requirements, assure payment for our services and, most importantly, provide you the very best healthcare. We hope that it is not too burdensome and look forward to seeing you in our office.

Sincerely,

AUSTIN NEUROLOGICAL CLINIC

AUSTIN NEUROLOGICAL CLINIC AND AUSTIN EEG LAB
Medical Science Center
711 West 38th Street, Building F
Austin, TX 78705
(512) 458-6121 CLINIC (512) 458-5223 EEG LAB
(512) 452-9171 FAX



AUSTIN NEUROLOGICAL CLINIC

FINANCIAL POLICIES

Austin Neurological Clinic has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. Following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. We encourage you to discuss your account, and any payment arrangements that you desire, with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1. **Insurance** – As a courtesy to our patients, we will file claims on all visits and procedures, if we are contracted with your insurance plan. There are many insurance companies with which we do not contract with, such as PHCS and Scott & White plans. This is ***not*** an all-inclusive list and you should check with your insurance company to be certain of our provider status. If we are *not* providers for your insurance plan, you will be required to pay for your services at the time of your appointment. We accept cash, check and credit cards (Visa, MasterCard & Discover). If we *are* contracted with your insurance plan, we will file claims and you will only be responsible for your office co-pay, deductibles and co-insurance. We will file claims with your insurance company for all hospital visits and procedures, regardless of insurance plan, but you will be expected to pay for any charges not covered by your plan. Please remember that insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.
2. **Referrals –** You are required to 1) know whether or not your insurance requires a referral and 2) be sure you have obtained a referral before you are scheduled to see one of our doctors. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor the dates and visits. Our office will not see a patient who does not have a valid referral.
3. **Ancillary Services** – Oftentimes our doctors will request that certain tests and evaluations be done to further diagnose or treat your condition. Your insurance company may have specific providers that are required or preferred for you to get the best benefit available under your insurance plan. We will assist you in making arrangements for tests and evaluations we require, but you will be responsible for telling our healthcare coordinator which facilities are on your plan. Failure to do so may result in charges to you by other facilities which your insurance company does not cover.
4. **No Insurance** – Patients who do not have insurance are expected to pay for all services rendered. Again, we accept cash, check and credit cards (Visa, MasterCard & Discover). We understand that individual circumstances may make it difficult to meet particular financial expectations and are happy to discuss other payment arrangements as needed.
5. **Returned Checks** – Your account will be charged a $25 fee for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and fee.
6. **Past Due Accounts** – Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligation to us may be turned over to a collection agency. Patients who have allowed their account to be turned to an agency will be expected to satisfy their financial obligation to us, and to pay for any future services in advance, before being seen by one of our doctors.
7. **Cancellations & No Shows** – Should you need to cancel or reschedule your appointment, please notify our office at least 24 hours before your scheduled appointment time to avoid any charge. **New Patients will be charged $100.00 and return/follow-up visits will be charged $35.00 for each no show or late cancellation**. ***As a courtesy*** we will attempt to remind you of your scheduled appointment time, but it is the **responsibility of the patient** to remember his/her appointment. Insurances carriers generally will not pay this type charge so it will be patient responsibility. Should you incur a charge - a clinic doctor will not see you until your account is paid in full.

Assignment of Benefits

I hereby give lifetime authorization for payment of insurance to be made directly to Austin Neurological Clinic for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.