OUR FINANCIAL POLICY
C.Philip O'Carroll, MD

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to any treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND AMERICAN EXPRESS.
WITH PRIOR CREDIT APPROVAL, WE CAN ARRANGE A PAYMENT PLAN.

1. As a courtesy to our patients, we will accept assignment of insurance benefits until such time that we know exactly what the final termination date will be for different insurances (except Medicare & GNP), however, we do require payment of any uncovered portion, such as deductibles and co-payment, to be paid at the time of service.
2. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. For visits that we have billed, if your insurance company has not paid your account in full within 90 days, any unpaid balance will be due in full.
3. The balance is your responsibility whether your insurance company pays or not.
4. For visits that we bill, we cannot bill your insurance unless you bring in all insurance information.
5. Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
6. Account balance over 90 days will be charged a service charge of 18%.
7. If you are a member of a Managed Care Insurance HMO or PPO, it is your responsibility to know your policy provisions and to inform this office.

INITIALS_____

Financial Responsibility

1. Adult patients and/or guardian or parents accompanying a minor are responsible for payment at time of service.
2. For unaccompanied minors, non-emergency treatment will be denied unless prior financial arrangements have been made.
3 Financial arrangements are available to our patients, but must be made prior to treatment. Such financial agreements are a commitment on your part as well as ours.
4 Patient and/or parent/guardian of minor is financially responsible for fees not covered by their insurance. Method of payment: **Check** **VISA/MASTER CARD** **American Express**
Credit Card #_____Exp_____

Signature on file: _____ INITIALS_____

5 A service charge of 18% per annum will be charged on overdue balances. INITIALS_____

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed consultation or appointment at the rate of $50. Help us serve you better by keeping scheduled appointments.

INITIALS_____

If it becomes necessary to utilize an outside collection agency to collect a past due balance, a fee of $40.00 will be added to an account before it is assigned.

INITIALS_____

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy and understand and agree to this financial policy.

_____ _____

Signature of patient/responsible party Date

C. PHILIP O'CARROLL, M.D.

Neurobehavioral Program Director
HOAG NEUROSCIENCES INSTITUTE

DIPLOMATE AMERICAN BOARD OF NEUROLOGY & PSYCHIATRY CLINICAL NEUROLOGY & ELECTROMYOGRAPHY

OFFICE FEE POLICY

• Any Forms (i.e., Disability, EDD, DMV, FMLA, etc.)	$35.00
• Medical Records (more than 10 pages)	$35.00
• Rx Prior Authorizations, when applicable	$35.00
• Returned Check Fee	$35.00

It is the patient's sole responsibility to pay all applicable co-pays and deductibles.

Thank you for your patronage and trust in our office. We strive to do the best we can and do not want any miscommunication of these fees to hinder our efforts. If you have any questions or need an explanation of any of the above-mentioned charges, please feel free to ask a staff member for assistance.

Please be prepared to pay any necessary fees at the time of your visit. We appreciate your understanding and cooperation.

By signing, I acknowledge that I understand and agree to the above Office Fee Policy.

Patient Signature:_____ Date:_____

Print Name:_____

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