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GOLDEN TRIANGLE NEUROCARE, LLP.

Financial Policy

To help us help you with the costs associated with your care, we have developed the following financial policy. Please read and sign a copy of this before we provide any treatment.

Insured Patients:

We welcome all patients and many, but not all insurance plans. Please be aware that all insurance co-payments, deductibles, and non-covered charges need to be paid in full at the time of service unless payment arrangements have otherwise been made.

This will require that you present your current insurance card at each visit. If you present an expired card or inaccurate information we will be unable to bill your insurance company, and you will be responsible for the total amount of billed services. It is your responsibility to know your insurance plan.

We try to the best of our ability to verify your insurance coverage prior to your visit based upon information given to us by your primary care doctor. A verbal verification of benefits or coverage by your insurance company is never a guarantee of payment. Your care is our responsibility; your bill is your responsibility. Balances in excess of 60 days must be paid prior to any additional services being rendered, unless you are on a pre-approved payment plan.

Our office does not accept Workers' Compensation Claims. If you provide insurance information for your visit and then file a claim with Workers' Compensation, your bill will then become your full responsibility and our office will discharge you as a patient from the practice.

Returned "NSF" checks:

There is a $25.00 service fee on all return checks.

Delinquent Accounts:

In the event that an account remains unpaid, delinquent accounts will be sent to a collection agency and a 35% service fee will be added to each open claim on your account.

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

We look forward helping you with your Neurological and Neurosurgical needs.

I have read and understand the Golden Triangle Neurocare, L.L.P. Financial Policy. I understand that ultimately I am responsible for payment in full of any outstanding balances incurred during the course of my treatment.

Patient signature: ______________________________ date: ______________________

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