GREAT VALLEY NEUROLOGICAL ASSOCIATES LLC
FINANCIAL POLICY

Great Valley Neurological Associates is dedicated to providing our patients with the best possible care and services. We ask your help by understanding and cooperating with our financial policy.

INSURANCES: We participate with several insurance companies. It is, however, the patient's responsibility to inquire with their insurance company to determine if Great Valley Neurological Associates is an in-network provider with his insurance company. Your health insurance coverage is an agreement between you and your insurance company and your doctor's bill for the services provided to you is an agreement between you and your doctor.

If we DO participate with your insurance company, all services performed in our office and at the hospital will be submitted to them, unless we have received prior notification of non-covered services. All co-payments and deductibles are the patient's responsibility. All copayments are due at the time services are rendered or a $5.00 billing fee will be added to your account.

If we DO NOT participate with your insurance company, we will submit a claim to your insurance company for you, but will not accept payment from them as payment in full for the services provided. All insurance carriers have a schedule of fees from which they pay, however, the doctor's fees may be more than what the insurance company shows on their schedule. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient.

HMO INSURANCES may require a referral for services. It is the patient's responsibility to obtain the referral prior to the appointment or the patient will be responsible for payments in full for that service at the time of service.

PAYMENT FOR SERVICES RENDERED: Our office accepts CASH, CREDIT and PERSONAL CHECKS for payment. A $25.00 transaction fee will be added to your account for any personal check returned by the bank for any reason. All payments are expected at the time of service as stated above and any outstanding balances are due within 30 days unless prior arrangements have been made with our Billing Dept. All balances that reach 90 days past due will be sent to a Collection Agency. Should your account be sent to a collection agency, you will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

ADMINISTRATIVE FEES including but not limited to the following will be the patient's responsibility; $50.00 Missed appointment fee for office visits, $100.00 for Missed office visits with a scheduled procedure $25.00 returned check fee, $5.00 copay billing fee, $25.00 fee to repeat a precertification for imaging if the patient fails to obtain the imaging before the precert expires or changes the site. Fees for record retrieval and copying, completion of forms and legal services may apply and are available on request.

I request that payment of Medicare and/or insurer benefits be made to me or on my behalf to Great Valley Neurological Associates for the services furnished to me by Great Valley Neurological Associates. I understand that if, under Medicare and /or insurer guidelines, a necessary service is determined to be non-covered, I will personally be responsible for any amounts denied or partially paid by the third payer.

I confirm that the personal billing & insurance information I have provided to Great Valley Neurological Associates is accurate and I agree to inform the office of changes. I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY GREAT VALLEY NEUROLOGICAL ASSOCIATES, AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Patient Name Printed:_____Date of Birth_____

Patient Signature:_____Date:_____

Printed Name of Patient's Agent/ Guarantor:_____

Signature of Patient's Agent/ Guarantor:_____Date:_____

REV: 11-2016