

# *Neurology and Sleep Medicine Associates*

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1492 South Mill Avenue, Suite 214, Tempe, Arizona 85281  
2919 South Ellsworth Road, Bldg 8, Suite 135, Mesa, Arizona 85212  
(480) 967-6888; FAX (480) 967-6887

## **Patient Payment Policy**

**Insurance:** We participate in most insurance plans. We bill your insurance company as a courtesy to you. Although we may estimate what your insurance will pay, it is the insurance company that makes the final determination of your eligibility. Please be aware that the balance of the claim is your responsibility whether or not your insurance pays the claim. **All co-payments and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

**Private Pay/ No Insurance:** Payment is due at the time of service. Payment will be accepted in the form of cash, debit or credit.

**Medicare:** Because we accept assignment with Medicare, it is mandatory that we bill your claim directly to Medicare. If you have Medicare only, you are responsible for 20% which is due at the time of service. Federal law requires us to bill you for deductibles and/or co-insurance 20%. Per Medicare guidelines we are unable to waive or write these fees off. Payment is due at the time of service. If you wish to have your secondary insurance billed, please make sure you provide all pertinent information before your visit.

**Referrals:** If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled. If you choose to keep the scheduled appointment without a referral, you will be responsible for full charges to be paid that day and also sign a waiver.

**Worker's Compensation:** We require written approval/ authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**Nonpayment:** If your account is past due, you will receive a letter from us stating you have 30 days to pay your account in full. Please be aware that if your balance remains unpaid, we may refer your account to a collections agency. There will be a 35% charge assessed to any account sent to collections. If this occurs, you will not be seen in the office until your balance is paid in full and all charges for future visits will be collected up front.

**Returned Checks:** There is a fee of \$25.00 for any checks returned by the bank.

**Missed Appointments:** Our policy is 24 hours notice for an appointment change. Sleep study appointments require a 48-72 hour notice. If a 48-72 hour notice is not given, you will be assessed a \$200 fee. We understand that emergencies arise. If an emergency keeps you from keeping your appointment, please contact us as soon as possible to reschedule. Please help us to serve you better by keeping your scheduled appointments. **If you miss 3 consecutive appointments, we will discharge you from the practice for non-compliance.**

**Medical Record Copies:** You will need to request copies of your records in writing. We are happy to email or fax your records to a secured fax free of charge. If you wish to have your records printed, you will be charged a reasonable copying fee of \$1 per page. There is also a \$5 postage fee if the records are to be mailed.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

