



# HEARTLAND NEUROSURGERY

## Financial Policy

Thank you for choosing **Heartland Neurosurgery** as your Healthcare Specialist. The following is a statement of our **Financial Policy**. We require that you read and sign before treatment.

**Co-payments:** Co-payments are due at the time of service.

**Non Insured or High Deductible Insureds ("Self-Pay"):**

**Office Visit:** If you are self-pay, you are required to pay \$100.00 prior to your appointment. You will be billed the remaining balance. A \$50.00 charge will apply to each follow-up visit at Heartland Neurosurgery.

**Surgery:** The full cost of the surgery is payable in installments until such deductible is reached in the case of high deductible insureds or until paid in full. It is our policy that you are required to pay 25% of the estimated total cost of the surgical charge. This is required to be paid no less than three days prior to date of surgery. The balance will then be billed to the patient. This does not include hospital charges.

**Non-Contracted Insurance Plans are considered out of network:** Please refer to the self-pay policy.

**Motor Vehicle Accident/Third Party Liability:** It is our policy to bill your health Insurance as primary for services rendered.

**Worker's Compensation:** We will file a claim with your employer or its insurance company as long as we have written authorization that your injury is a Worker's Compensation claim.

**Legal Claims:** Heartland Neurosurgery does not see patients that have active or open legal claims. We would be happy to see you once your legal issues have been resolved.

**Missed Appointments:** In order to provide the best possible service and availability to all our patients, it is our policy to charge a no show fee of \$50.00 for any appointments missed or cancelled less than 24 hours prior to your appointment.

**Authorization for Release of Information**

I hereby authorize Heartland Neurosurgery to release information requested by my insurance company or Worker's Compensation carrier. I also authorize Heartland Neurosurgery to release information to any hospital, surgery center, treatment or diagnostic center or physician I may be referred to by the office.

**Assignment of Benefits**

I hereby represent and agree as follows: a) I represent that I currently maintain medical insurance coverage which will reimburse the charges for medical services provided; b) If my medical insurance is not sufficient to satisfy the charges in full, or the insurance company denies some or all of the claim, I will be fully responsible for payment of any balance due. In consideration of these medical services, I hereby assign, transfer, and set over to Heartland Neurosurgery all of my rights, title and interest to medical reimbursement benefits under my insurance policy (s) and/or any pending or future lawsuits, claims or actions.

**Verification of Benefits**

I acknowledge that I have provided Heartland Neurosurgery with all known insurance information, which may be applicable to help expedite payments. This includes but is not limited to all insurance policies, correct insurance data, and pre-certification information. I agree to immediately provide Heartland Neurosurgery with any revised or new health insurance information.

**Guarantee of Payment:**

I agree, whether I sign as patient or as agent, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself and agree to be responsible for the payment of any and all expenses incurred at Heartland Neurosurgery in accordance with the regular rates and terms of Heartland Neurosurgery.

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Signature

(Relationship to Patient)

Date

By signing this I thoroughly understand and agree to the terms of the above stated policy.