The Metropolitan Neurosurgery Group LLC
1010 Wayne Avenue, Ste. 420, **Silver Spring**, MD 20910
Phone: 301-557-9051 Fax: 301-654-9394

FINANCIAL NOTICE

I, _____ acknowledge that, if I have an appointment scheduled with Metropolitan Neurosurgery Group, LLC and do not cancel within the given time my credit card will be charged respectively.

I acknowledge that if my account is turned over to collections there is a **$50.00 collection fee**. The office will work on a payment plan if necessary according to the following structure:

$50 balance or less: Entire balance is **due the first month**

$51 - $500 balance: $50 minimum monthly payment

$501-$1000 balance: $100 minimum monthly payment

$1001-$2500 balance: $200 minimum monthly payment

Over $2500 balance: minimum monthly payment will need to be approved by management.

I acknowledge that there will be a **fee of $25.00 for all medical forms and letters to** be completed by our office. Payment will be due once these are ready. These will be done within 10 working days. If I need them expedite, an additional $15.00 will be charged.

Please be advised **all returned checks and declined credit card transactions will be subject to $35.00 processing fee**.

I, the undersigned, do hereby understand and accept these policies of Metropolitan Neurosurgery Group, LLC

Signature of patient: _____Date: _____