Premier Neurology
MEDICAL GROUP

OFFICE POLICY

1. **Patients who carry medical insurance**: Professional services are rendered and charged to the patient and not the insurance company. We are happy to provide you with the courtesy of billing your insurance company for services rendered. However, please understand that you are ultimately responsible for payment, not your insurance company. I agree to pay all collection costs and reasonable attorney fees in collecting outstanding balances. I authorize Premier Neurology Medical Group, Ravinder Singh, MD and their collection agency to verify my insurance information.

2. **Cash-paying patients**: You are required to pay 100% of the total charge at the time medical services are rendered unless previous arrangements are made.

3. **Medicare:** Our office accepts **Medicare** assignment. Patients covered by Medicare are responsible for deductible, co-insurance and any non-covered services. You will be notified prior to a service being rendered if it is not a Medicare covered service.

4. **Payment Terms:** I understand that invoices sent by Premier Neurology Medical Group are due upon receipt and that failure to keep my account current may result in my being denied additional services.

5. **Non-covered convenience items:** We provide a variety of items and services that are generally not covered by your insurance. These will be the sole responsibility of the patient. These services include:

• Telephone Consultations:	$75.00
• Letters/Paperwork/Form Completion:	$25.00
• Non-Emergency After-Hours Prescription Refills:	$25.00
• Copy Medical Records:	$15.00

6. A charge of **$50.00** will be made for all **returned checks**.

7. All missed cancelled or rescheduled appointments, without 24 hours notice, will be charged a **no-show fee of $50.00**, and is the sole responsibility of the patient. This is not an expense benefit covered by insurance companies. This fee must be paid prior seeing the doctor.

8. **Co-pay** is due and payable at the time of the visit.

9. I consent to the taking of my photograph for Medical Documentation (goes in medical record).

By signing this agreement, I acknowledge that I have read and agree to the terms of this office policy.

Name of Patient:_____ Date:_____

Signature of Patient or Guardian:_____

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