NEUROLOGY ASSOCIATES OF ROCHESTER, P.C.
20 Hagen Drive, Suite 300, Rochester NY 14625, T(585)586-7550

FINANCIAL AGREEMENT

Insurance Coverage
This office makes no claim that your insurance policy will cover all services provided. Insurance policies may vary greatly in terms of deductible and percentage of coverage for neurology consultation and testing. We require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances to this office. After verification of your insurance coverage, we will bill your insurance provider for the services that you receive.

Payment Arrangements
If you have a contracted amount for a copayment, that amount is due on each visit. If you have a deductible we require that you pay 50% toward today's charges and 50% on each visit. Your full portion of the bill is expected to be paid after payment is received from your insurance provider. Any unpaid balances will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 2% applied per month. Any positive balances will be refunded to you within 30 days of receiving your Insurance Explanation of Benefits (EOB).

Assignment of Benefits
By signing this form you authorize payment of medical benefits to be made directly to this office. If your insurance provider sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt.

Release of Information
By signing this form you are also authorizing this office, upon request from your health insurance provider, to release any medical or other information necessary to process the claim. You also acknowledge and request payment of government medical benefits to this office.

Termination of Care
If you are discharged from the practice OR voluntarily suspend or terminate your care at any time, all charges for professional services are immediately due and payable to this office. All services rendered by this office will be charged directly to you. You are personally responsible for payment regardless of your health insurance coverage.

Please contact us if you have any questions regarding the financial policy of this office.
I have read and agree to this financial agreement.

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NAME (printed) Signature Date