

GREELEY & ASSOCIATES

Northwest Neurological, PLLC

Financial Policy

Initial that you have read this section []

The patient, spouse or guardian is responsible directly to Northwest Neurological, PLLC (NWN) for payment at the time of service unless other arrangements are made in advance (e.g. medical insurance). The fee for services provided is a contract between **you** and NWN, not between your insurance and NWN. In other words, the account balance is **yours**, at times paid for in part by your medical insurance, but nonetheless **your responsibility** to insure that NWN is paid. It will also be your responsibility to insure that your account is paid, will be paid by insurance, or a payment plan is established for services previously provided by NWN before more service can be provided by NWN; or a credit card or cash payment may be used to insure payment of future services.

NWN charges everyone 1.8 times the Medicare allowable for all services. To offset this increase, a 40% discount for day-of-service cash or credit card payment will always be accepted. The Medicare fee schedule can be found at any time on the Internet at:

https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp?locality=WA?checkXwho=done

If Medicare does not pay for the service provided, and/or it is a service requested by you (the patient) the charge will be calculated based on 15-minute increments of time. However, in these situations it is highly unlikely that your insurance will pay for the service(s). You also need to read and understand the following as part of the NWN financial policy:

- If you cancel or reschedule your appointment in less than 24 hours of the scheduled time or if you “No Show” (e.g. do not arrive at the scheduled time; or in any other way, personally delay the time needed for the NWN provider to adequately perform the service requested in the time allowed) **you will still be charged** for that scheduled visit. **It is highly unlikely that your insurance coverage will pay for that charge but you are still responsible for payment.**
- NWN will add \$30 to your account for every returned check.
- A \$5 surcharge will be added for every statement above and beyond the first statement sent to you for payment.
- If NWN has to resubmit an insurance claim because you provided inaccurate information a \$30 charge will be added.
- An annual interest rate of 18% (1.5% per month) will be added to your balance if >30 days old.
- If your account is ever referred for collection, there is a non-refundable collection fee of \$30 and an additional 70% of the outstanding balance, together with additional charges for court costs and reasonable collection agency and attorney’s fees added as necessary.
- We reserve the right to charge for copying of medical records in accordance with Washington State law.

Insurance Release and Lifetime Authorization

Initial that you have read this section []

“If I have medical insurance I will provide Northwest Neurological, PLLC (NWN) with everything necessary to bill my insurance correctly to insure proper payment. It is my responsibility to know what my insurance company covers and/or requires for pre-authorization of services, payment of delivered services and requirements for future referrals.

I request that payment for authorized insurance benefits be made to NWN for services provided to me by NWN. I authorize any holder of medical information about me to release to my insurance company, and its agents, any information about me to determine these benefits or the benefits payable for related services. I assign directly to NWN all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature noted below on all insurance submissions”.

I _____ **have read and understood this form, and all my questions were answered:**
(print name)

Authorized Signature _____ Date _____

- patient
- financial Power of Attorney (documentation provided)
- other: