LANCASTER NEUROSCIENCE & SPINE ASSOCIATES
PATIENT FINANCIAL POLICY

Thank you for choosing Lancaster Neuroscience & Spine Associates for your care. Our physicians are committed to the success of your medical treatment and care and realize that communication is vital to the patient's well-being. A mutual understanding is part of our relationship and we need your assistance and understanding of our financial policy.

It is important for you to understand the terms of your health insurance policy. Your policy is a contract between you and your insurance carrier. Patients are responsible for knowing which facility is participating with their insurance carrier in regards to physicians, hospitals, and outpatient testing.

Participating Insurances: Valid health insurance information must be provided to us to ensure appropriate reimbursement for your care. We participate with the majority of managed care plans offered. You may reference our list of participating carriers on our website at www.lancasterneuroscience.com. If your insurance does not pay 100%, you will be responsible for any deductible, co-payment, coinsurance, and any non-covered services.

Non-Participating Insurances: Valid health insurance information must be provided to us to verify if your policy has "out-of-network" benefits. You will also be responsible for any balance over the reasonable and customary charges arbitrarily determined by your insurance carrier, in addition to a higher deductible or co-insurance level.

Secondary Insurance: As a courtesy to you we will bill your secondary insurance. Valid health insurance information must be provided to ensure transferring and billing of balances after receiving your primary carrier's reimbursement.

Medicare: As a participating provider of Medicare Part B we will only bill you for your Medicare deductible and coinsurance. NOTE: You will be informed of any services which are not covered by Medicare prior to services being rendered. If you choose to have the services rendered your signature will be required stating you accept the financial responsibility for these services.

Workers Compensation / Auto Insurance: We will submit claims to a valid carrier. If you have health insurance, you will be required to provide the information to us in case your WC/Auto benefits are denied or exhausted. All remaining balances or denied services will be your responsibility even if claim is in litigation.

Referrals: It is your responsibility to bring any required referral for treatment to your visit. If you do not have the required referral your appointment will be rescheduled.

Co-Pays: Co-pays are due at the time of service. If you are unable to pay your co-pay a $10.00 surcharge will be applied to your account.

Self-Pay: If you do not carry insurance - payment is expected at time of service unless payment arrangements have been established with our billing department prior to your visit. No surgery will be scheduled until financial arrangements have been made with our Billing Coordinator. We do offer a reasonable discount for our self-pay patients.

Missed Appointments: We request if you are unable to keep a scheduled appointment that you cancel no later than 24 hours prior to your appointment time. The first time you fail to cancel your appointment, as a courtesy, we will contact you to reschedule, the second time you miss an appointment you will be charged a $30 "no-show" fee and receive a letter reiterating our policy, and the third time you miss an appointment you will receive a letter discharging you from the practice.

Balance: All patient balances (after insurance has been processed) will be due in full after 30 days unless payment arrangements have been established with our billing coordinator.

Collections: Any patient that has been placed in collections must pay any outstanding balances owed along with the collection agency fee to the practice before an appointment will be scheduled.

Form Completion: Most forms are completed within 7-10 business days and pre-payment of $5 per form is expected prior to completion.

Payment Plans: Our office will be happy to work with you in order to pay any balance due to our practice.

Payment Methods: We accept cash, check, MasterCard, Visa and Discover.

Refunds: Refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full. Refunds less than $10.01 will not be issued, unless requested, and will be credited to your account at our practice. Patients will be notified of this.

By signing this document, I _____, have fully read and understand the financial policy of Lancaster Neuroscience & Spine Associates. I hereby consent to allow Lancaster NeuroScience & Spine to reach me via: (check all that apply)

_____ Home phone (_____) _____-_____

_____ Cell Phone (_____) _____-_____

_____ Work Phone (_____) _____-_____

I will cooperate with the billing department of Lancaster Neuroscience & Spine Associates to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

_____
Printed name of patient / parent / guardian

_____
Signature of patient / parent / guardian

_____
Date