NOVA Neurology Center

FINANCIAL AGREEMENT & RELEASE OF INFORMATION

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by NOVA Neurology Center and/or affiliated medical staff member(s) on behalf of myself and my minor children, including stepchildren.
The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, State law requires a sample of my blood to be tested for the presence of infectious diseases.

RELEASE OF INFORMATION

I hereby authorize the release of any and all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment in the payment of my treatment including but not limited to insurance payers, HMOs, workers compensation carriers, Medicare, Tricare and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become part of my medical record.
I hereby authorize a query of medication history and/or formulary information within the Electronic Medical record in order for drug eligibility and coverage. _____ (initials)

PRESCRIPTION HISTORY CONSENT

NOVA Neurology Center uses an electronic medical record system (EMR) in which the physician is able to prescribe medications electronically. I give permission to NOVA Neurology Center to send my prescription(s) electronically. Also, I agree that NOVA Neurology center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. _____(initials)

FINANCIAL POLICY

I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from third party claims for injuries treated hereunder, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest) due hereunder is to be made to NOVA Neurology Center. I understand that if I have insurance, my insurance policy is a contract between me and my insurance company. I am responsible to NOVA Neurology Center for any charges not covered by my insurance, including but not limited to co-payments, deductibles and fees for non-covered services. The patient and undersigned guarantor are primarily liable for payment of the patient's account and NOVA Neurology Center will send all appointment reminders and billing information to the person responsible for payment of my bill _____(initials)
It is their sole responsibility to comply timely with all requirements, and supply all information and documents necessary to obtain payment of benefits by any third party or governmental entity as listed above. Some insurance plans (i.e. Medicare, Blue Cross, CHAMPUS) require that lab work be billed directly by the laboratory performing the testing. In these instances, a separate statement and bill will be sent from the lab performing the test.
The return check fee is $35.00
Failure to call the office 24hrs prior to your appointment to cancel or re-schedule it will result in a $50.00 charge.

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service.
The undersigned agree(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If payment is not made, I understand that NOVA Neurology Center may take action to collect its fees. I agree to pay all costs incurred by NOVA Neurology Center for collecting its fees equal to thirty percent (30%) of the unpaid bill and if applicable, all attorneys' fees. _____ (initials)

ACKNOWLEDGMENTS

NOTICE OF PRIVACY PRACTICES. I acknowledge that I have received, have previously received or have been offered but declined to receive the NOVA Neurology Center Notice of Privacy Practices. _____ (initials)
By providing my E-mail address, I authorize NOVA Neurology Center to use the address for the purpose of communicating health-related information or services. I acknowledge that I may opt-out of such communication at any time and my E-mail information will not be shared with any organization outside of NOVA Neurology Center.
It is patient's responsibility to know their insurance carrier's patient responsibilities and procedures. If proper procedures are not followed, the patient may be liable for full payment of the bill. If the insurance carrier requires a referral and/or prior authorization, contact your primary care physician prior to your appointment. The patient is responsible to verify the referral is valid for the follow-up visits. _____ (initials)

Thank you for choosing NOVA Neurology Center as your health care partner

Patient Name (please print) _____ Med. Record No. _____

Patient/Guarantor Signature _____ Date _____

MEDICARE PARTICIPANTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to NOVA Neurology Center for any services furnished to me. I authorize the holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for payable related services. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____