Northwest NeuroSpecialists, PLLC
Patient Financial Responsibility Agreement

Your Financial Responsibility

Each time you come to see your doctor, we will ask to see your personal identification and proof of insurance so that we can properly bill your insurance company(ies) and charge you the correct amount.

Payment: Any amount you owe is due when you arrive to see your provider. Cash, personal checks and credit cards are accepted as payment. If your bank returns your check to our office as unpayable, there will be a fee of **$40.00** charged to you. A collection agency will be used to collect on delinquent accounts.

Insurance: If your visit with our provider is not covered for any reason by your insurance company, you are responsible for paying for the entire visit based on our fee schedule.

No Insurance: If you do not have insurance, you will need to pay the full cost of your visit at the time of service. A discount will be applied at the time of service.

Appointment Cancellation: We want to make sure our patients have access to their providers when they need them, so we pay close attention to how we schedule appointments. If you arrive late for your appointment, you may be asked to reschedule for another time. Please give out office **at least 24 hours advance notice** (not including weekends) when you need to change or cancel an appointment, **otherwise a $50.00 cancellation fee may be charged.** If you no-show to your appointment a **$50.00 no-show fee may be charged.** Repeatedly no showing for your appointment may lead to termination of the relationship between you and your medical care provider

Appointments: Northwest NeuroSpecialists care team includes **Advanced Practitioners**. Your provider may ask you to follow up with these providers or see them when the provider is unavailable.

I have read this document and agree to the terms for financial responsibility

- **I understand it is my responsibility to notify Northwest NeuroSpecialists, PLLC of any changes to my insurance or demographic information**
- **I understand my responsibility for payment to Northwest NeuroSpecialists, PLLC and have been given the opportunity to ask questions about it.**
- **I understand the cancelation and no-show policy of the practice**

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Patient or Legal Representative Printed Name

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Patient or Legal Representative Signature Date