220 EXECUTIVE CENTER PARKWAY
FREDERICKSBURG, VA 22401
(540) 899-2900 • FAX (540) 372-6928

NEUROLOGY ASSOCIATES of Fredericksburg

WELCOME TO OUR OFFICE: Please complete all forms and provide them to the receptionist upon your arrival. Please bring your insurance card(s) and drivers license so that we may make a copy. **If your insurance requires a co-payment and/or an insurance referral/pre-authorization form, we will need them at time of service.**

TO ALL PATIENTS: All professional services rendered are charged to the patient and are due at the time of service, unless you have verification of insurance coverage for all diagnostic visits and procedures. If you are unable to pay at the time of service, please ask to speak to a billing specialist.

TO OUR PATIENTS WITH INSURANCE COVERAGE: We will automatically file all charges with your insurance company once you have given us your complete insurance information. We will ask to copy your insurance card(s) for verification. Please remember your insurance coverage is a contract between you and your insurance. We will do everything possible to expedite your claim with proper filing and forms; however **YOU ARE** responsible for all fees.

TO OUR HMO PATIENTS: It is your responsibility to obtain the proper referral/pre-authorization form from your Primary Care Physician. Our HMO contracts state that all patients must have valid referral/pre-authorization form prior to their visit. **Without this referral you will be asked to reschedule your appointment or to sign a waiver acknowledging no referral/pre-authorization and your agreement to pay all charges in full.**

TO OUR WORKER'S COMP. PATIENTS: If your appointment is covered under Worker's Compensation, we will need the following information prior to scheduling so that we may obtain verification: Worker's Compensation Name, Address, Phone Number, and Contact Person, Claim Number, and Date of Accident. If you were injured while in the course of your employment we will file your compensation claim for you once we have verification. **We will ask for your personal health insurance for future use if needed.**

TO OUR AUTO ACCIDENT/PERSONAL INJURY PATIENTS: If your injury/illness is due to an auto accident or personal injury, you are responsible for filing the auto/personal liability insurance claim yourself. Payment in full will be expected at the time of your office visit. If you are not prepared to make payment in full at time of service, you will be asked to reschedule your appointment. If you have Medical Insurance that our office participates with, then we will file the claim for you. **However, if the claim is denied, then you are responsible for payment in full within 30-days of the denial. (Patient's Initials: _____)**

PLEASE BE ADVISED THAT IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT, YOU ARE REQUIRED TO CALL OUR OFFICE TO CANCEL NO LESS THAN 24 HOURS PRIOR TO YOUR APPOINTMENT TIME. NO CALL/NO SHOW PATIENTS WILL BE CHARGED A FEE OF $50.00. (Patient's Initials: _____)

NEUROLOGY ASSOCIATES OF FREDERICKSBURG
CONTRACT

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that Medical/Dental Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information.

The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, the undersigned understands that medical, personal, and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's Business Associate in compliance with the Federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I ☐ **am** an active duty member of the U.S. Armed Forces.

☐ **am not** an active duty member of the U.S. Armed Forces.

Date _____ Responsible Party _____