Abington Neurological Associates, Ltd.

Financial Disclosure

We, the staff of Abington Neurological Associates, Ltd. thank you for choosing us as your healthcare provider. We believe that it is important for our patients to understand their financial responsibility. Please read the following information and sign below acknowledging your understanding. Thank you.

We accept cash, check, Visa and MasterCard.

A $25.00 service fee will be charged for all returned checks.

Please remember that your insurance policy is a contract between you and your insurance carrier. We will gladly submit the claim to your insurance carrier on your behalf, for insurances that we are in network. Please note that any copays, deductibles or non-covered services are your responsibility, and will be collected on the day of your appointment. If a referral is not obtained prior to your appointment, we reserve the right to reschedule your appointment or bill you for services rendered. If you choose to be seen at our practice, outside of your insurance network/coverage, you will be solely responsible for all fees. In addition, if you require testing or medication, that requires preauthorization; our office may not be able to obtain this for you, due to our non-participation with your plan.

Any non-covered services such as Injections of any kind, including Botox, Occipital, Nerve Blocks of any type, or infusions will be the responsibility of the patient.

Form Fee: We will be happy to fill out any forms (i.e. disability, FMLA, life insurance, etc.) for a $15 service fee plus $5 per page.

Missed Appointments: We require notice of cancellation 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointment without notifying us in advance, a no show fee will apply. **This fee is $100.00 for new patients and $75.00 for follow ups**. **Repeated missed appointments without notification, or frequent cancellations may result in being discharged from the practice so that we can provide care to other patients.**

We realize that temporary financial problems may affect timely payment of your account. If this should occur please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification.

I have read and understand the above financial policy.

_____ _____

Print Patient Name Date of birth

_____ _____

Signature of Insured or Authorized Representative Date

_____

Witness