NEUROLOGY ASSOCIATES OF KANSAS
3243 East Murdock – Suite 104
Wichita, Kansas 67208

FINANCIAL POLICY

As your physician, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy.

All co-payments, deductibles and previous balances due must be paid at time of service. If you have insurance, please present your insurance card for verification. If your insurance changes, please notify us immediately.

Your insurance plan may require that you have a pre-authorized referral(s) for office visits, testing and lab services from our office and/or ancillary facilities as ordered by our physician. Without an authorized referral, the appointment will need to be rescheduled. If you choose to keep the appointment without a referral, payment in full will be necessary prior to visit. If your insurance plan requires that you use specific ancillary facilities for additional medical services ordered by the physician, it is your responsibility to inform the office staff of that requirement.

We will be pleased to discuss your proposed treatment and cost of those services. If you have questions regarding coverage of a medical service by your insurance company, we will assist you in finding the information. Your insurance is a contract between you, your employer and the insurance company and we may not be able to receive specific coverage information for you contract.

We must emphasize that as your physician, our relationship and concern is with you and your health, not with your insurance company. **All charges for services are your responsibility at time of service.** Any balance on your account after 90 days will result in collection action. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our office promptly for assistance in management of your account.

Consent to Telephone Calls for Financial Communications.

______(Patient initials) I agree that, in order for **Neurology Associates of Kansas**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Neurology Associates of Kansas** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Neurology Associates of Kansas** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
If you have any questions regarding the above policy or any uncertainties regarding insurance coverage or request for payment, please do not hesitate to ask. We are here to help you.

I understand and agree to the Neurology Associated of Kansas Financial Policy.

Signature ____ Date:___________________

Witness:____ Date: ___________________

(Revised 1/8/2017)