NEUROCARE OF LOUISIANA

648 Crestwood Blvd
Covington, LA 70433
Ph. 985-805-2555
Fax 985-400-5303

FINANCIAL RESPONSIBILITY POLICY:

Neuro Care of Louisiana, LLC ("Neuro Care") participates in the Medicare and Louisiana Medicaid programs as well as other commercial insurance products. **You MUST bring your insurance card(s) to every visit.**

- If Neuro Care participates in your insurance plan *you will be responsible for all copays, deductibles, and coinsurance amounts at the time of service*, as per your insurance policy. *You will also be responsible* for any services not covered by your insurance plan.
- If Neuro Care does not participate in your insurance, we will file your insurance as a courtesy but *you will be responsible for all charges not paid* by your insurance.

You understand that you are financially responsible for all Clinic charges unless covered and paid by your third party insurance as explained above. If you should default on your financial responsibility, you understand that your account may be turned over to a collection agency. If that occurs, you may be charged for all reasonable collection fees incurred by the Clinic. You consent to receive communications regarding your account from Neuro care or its collectors by any phone numbers you provide including cell, employer, and home landline numbers. You consent to accept and acknowledge via electronic communication (email, text, etc.) any payment plan reached with Neuro Care regarding the payment or satisfaction of any outstanding patient responsibility pursuant to Louisiana Revised Statute 9:2607.

Assignment of Benefits

Medicare and Medicaid: You hereby request that payment of authorized Medicare/Medicaid benefits for services rendered by Neuro Care on your behalf, shall be made to Neuro Care, and you specifically assign such benefits to Neuro Care. You hereby certify that all information given by you in connection with applying for such benefits is correct and complete in all respects. You understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid Program and that you *may be responsible for these charges*. You also understand that you are required by Medicare/Medicaid Programs to pay any and all copays, coinsurance, and deductibles upon demand by Neuro Care, at the time of service.

Commercial Insurance: You hereby assign to Neuro Care all rights, benefits and interest under any insurance policy, health plan, or workers compensation plan in consideration for services rendered by Neuro Care. You hereby authorize payment of such benefits directly to Neuro Care for medical care, procedures, testing and treatment you receive at Neuro Care. You understand that *you are required to pay any and all copays, coinsurance, and deductibles upon demand* by Neuro Care at the time of service.

Consent to Release Health Information for Billing and Payment Purposes

You hereby consent to the release of your health information by Neuro Care for the purpose of obtaining authorization and payment of services rendered to you by Neuro Care. Your consent does NOT waive your privacy rights under federal law (known as the Health Insurance Portability and Accountability Act, or HIPAA).

I have read, understood, given the opportunity to discuss and ask questions, and agree to the above.

Patient first and last name: _____

Signature: _____

Date: _____

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