Sandia Neurology PC Privacy and Payment Policy Overview 1/6/19

To the patient : You have the right to be informed about your condition and the recommended diagnostic or medical procedures recommended so that you may make the decision whether or not to undergo recommended treatment. This consent is an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment or procedure for any identified neurological conditions. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you indicate that you intend that this consent is continuing indefinitely and you consent to treatment at this office. This consent remains effective until it is revoked in writing, and you may at any time discontinue services. You have the right to discuss the treatment plan with Dr. Harris about the purpose, risk and benefit of any test or treatment recommended for you. You have the right to ask questions if you have any concerns. By signing this you give your consent to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought you to this clinic. You also consent to allow Dr. Harris to review any medical information including tests and labs on the New Mexico Health Information Exchange Website on my behalf. _____Initials

The following applies to payment issues only. If you disagree with any of the following, you may elect to pay in full today and receive a paid invoice to submit to your insurance company. **_____ Initials**

I understand the benefits provided by my insurance plan. I hereby assign all medical insurance benefits to which I am entitled to Sandia Neurology PC (SNP). I also authorize SNP to submit any and all appeals if my insurance denies benefits. I authorize SNP to share part or all of my medical record to outside medical providers, insurance companies, disability determination, legal representative, or workman's comp carriers. I agree to provide accurate and complete insurance and personal id at every visit.

I agree to pay in full any balance not covered by my insurance which may include any NO SHOW fees, form fees, or failed appeals. I will pay any NM gross receipts tax on patient payment for NON - NM based plans. (Pres, NMHC, and BCBS NM are exempt.) I will pay copay and estimated payment at time of the visit or immediately when detected.

I agree to leave a valid credit card securely on file with the office which is accessible only to Dr. Harris in the event that I have an outstanding balance. I understand that after my insurance has paid their specified reimbursement to SNP and I still have a balance, SNP will leave me a courtesy message indicating SNP will automatically run the card I leave on file. I may elect to pay in cash or send a check or use another card for the balance. I will have only 30 days from the day of the visit to pay in full or set up a payment plan. I will notify SNP immediately if I wish to use a different mode of payment. If I do not alter the payment plan, my card will be run the following day. If my card is denied, I will be notified and sent to third party assistance with a service fee $20.00. ***Statements are no longer mailed to you.***

I agree to pay a NO SHOW fee of $75 for missing any scheduled appointment giving less than 1 business day cancellation notice, and/or $150 for missing an injection or EMG appointment that I scheduled and did not cancel giving at least 1 business day advance notice**.** ***Monday morning appointments must be cancelled by Thursday noon.*** **SNP allows last minute scheduling to avoid NO SHOW fees.**

I understand that I will be charged a $20 late fee for unpaid bills 30 days after the visit. After 60 days of nonpayment, my account will be sent to third party collections attempts, the fee will be updated to be either $35.00 or 35% of the amount due, whichever is greater. I will not be rescheduled or be allowed to obtain refills until my outstanding balance is paid or a payment plan has been initiated.

Printed Name _____ Signature _____

Date ____/____/_____ SNP Witness _____

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