

**PATIENT RESPONSIBILITY POLICY: LYERLY NEUROSURGERY**

**PATIENTS ARE RESPONSIBLE FOR KNOWING, WHICH FACILITY IS PARTICIPATING WITH THEIR INSURANCE CARRIER IN REGARDS TO HOSPITALS, OUTPATIENT TESTING, LABS, AND ETC.**

**PURPOSE:** TO INSURE ALL PATIENT RESPONSIBILITY BALANCES ARE COLLECTED IN A TIMELY MANNER.

**POLICY:** TO COLLECT ALL PATIENT RESPONSIBILITY BALANCES IN THE FOLLOWING MANNER.

**RATES:** WE MUST COMPLY WITH OUR **CONTRACT NEGOTIATIONS** CONSEQUENTLY **OUR RATES ARE FIXED.**

**COPAYS:** ALL COPAYS ARE COLLECTED PRIOR TO THE VISIT. IF YOU ARE NOT PREPARED TO MAKE YOUR COPAY YOUR VISIT WILL BE RESCHEDULED.

**INSURANCE:** IF YOUR INSURANCE **DOES NOT PAY** 100%, YOU ARE RESPONSIBLE FOR PAYING THE BALANCE **BEFORE** EACH VISIT AND/OR SURGERY.

**SELF PAY:** ALL VISITS TO THE DOCTOR WILL REQUIRE PAYMENT AT THE TIME SERVICES ARE RENDERED. NO SURGERY WILL BE SCHEDULED UNTIL FINANCIAL ARRANGEMENTS HAVE BEEN MADE WITH THE BOOKKEEPER.

**BALANCE:** ALL BALANCES AFTER INSURANCE HAS PROCESSED WILL BE **DUE IN FULL AFTER 30 DAYS.**

**COLLECTIONS:** ANY PATIENT THAT HAS BEEN PLACED IN COLLECTIONS MUST PAY ANY PRIOR BALANCE OWED TO THE PRACTICE AND THE COLLECTION AGENCY FEE IN CASH BEFORE THE PRACTICE WILL SEE YOU AGAIN.

**PAYMENT PLAN:** THE PAYMENT SCHEDULE IS AS FOLLOWS:

BALANCE	PAYMENT PER MONTH
0 TO \$99	\$25.00
\$100 TO \$499	\$50.00
\$500 TO \$999	\$100.00
\$1000 TO \$2500	\$200.00
\$2500 TO \$5000	\$300.00
OVER \$5000	OVER \$500.00

PATIENT SIGNATURE \_\_\_\_\_

WITNESS \_\_\_\_\_

DATE \_\_\_\_\_