Financial and Clinic Policy Agreements

Insurance Payment/ Deductibles/ Co-Payments/ Co-Insurance:
Per my insurance contract, I understand that deductibles, co-payments and co-insurances are due at the time of service. If I am unable, I agree to reschedule my appointment. I authorize Alliance Neurology or insurance company to release any information required to process my claims. I authorize my insurance benefits to be paid directly to Alliance Neurology Consultants/Byung Chan T. Ahn, M.D. I authorize the use of my signature on all insurance submissions. If I do not have any insurance coverage, or insurance with which Alliance Neurology Consultants does not participate, payment is required in full at time of service. **I understand that Alliance Neurology/Byung Chan T Ahn, M.D. is a contracted provider for many insurances and it is ultimately my responsibility to confirm with my insurance company the participation of Alliance Neurology/Dr. Ahn, M.D. in my insurance policy. I also understand that it is my responsibility to obtain any authorizations needed to be seen at Alliance Neurology. I acknowledge billing insurance is a "courtesy" and any disputed claims are my financial responsibility.**

Accurate Updated Insurance and Contact information:
I accept my responsibility to provide accurate contact and insurance information. I must notify Alliance Neurology Consultants within 30 days of my new insurance, so that all claims can be re-filed as appropriate. In the event that my insurance information I provided changes or is inaccurate, I will notify the office within 30 days. If I fail to do so, any outstanding balances associated with denied insurance claims will become my responsibility.

Collections:
I understand that once an account is placed to a collection agency, all future services must be paid in full at time of service, and I will be responsible for all collection costs equal to 40% of my outstanding balance, but no less than $45.

No Show/ Late Cancellations:
If I fail to notify the clinic more than 48 business hours prior to my appointments, I agree to pay a $45 no-show and cancellation fee. I understand and agree to be discharged from the practice with a 30-day notice if I cause 2 consecutive no-shows without excusable reasons.

Automated Text and/or Calls for Appointment Reminder:
I give consent to receive automated phone texts and/or phone calls and emails to be reminded of upcoming appointments.

Late Payment and Returned Checks:
I agree to pay $25 fee for any late payments or returned checks before the next appointment in cash or credit card.

COVID19 Clearance Attestation:
I confirm that I currently have no symptoms of COVID19 such as fever, cough, sore throat, body ache, uncontrolled diarrhea. I will notify Alliance Neurology Consultants if any of these symptoms develop.

By signing here, I agree to adhere to the above policies, and attest that my insurance and contact information I provided is accurate and up-to-date.

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SIGNATURE **DATE**