NORTH COUNTRY NEUROLOGY, P.C.
FINANCIAL AGREEMENT

Financial Agreement: I agree that in return for the services provided to me by North Country Neurology, PC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to North Country Neurology, PC, for payment. We accept cash, check, Visa or MasterCard.

Copayments/Deductibles: If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to North Country Neurology, PC, at the time of service.

Collections: I acknowledge and agree that should my account be referred for collection with Central Service Bureau, I will pay a collection expense of $15.00 for each referral, plus any reasonable attorney's fees. Any benefits, of any type, under any policy of insurance insuring the patient, or any other party liable for the patient, are hereby assigned to North Country Neurology, PC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Cancel/Reschedule Appointments: North Country Neurology, PC, requires notice to change or cancel any type of appointment 24-48 hours prior to the scheduled appointment. If a patient misses an appointment without a prior phone call to our office, there will be a missed appointment charge of $25.00. If you are scheduled for an MRI, EMG/NCS of the extremities, EEG or Sleep Study appointment you will be charged $100.00 (for MRI $100/scheduled slot).

Returned Check Fee: I understand and agree to pay a $35.00 service charge to North Country Neurology, PC, for any checks returned for insufficient funds.

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to North Country Neurology, PC, for services furnished me by North Country Neurology, PC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency show. North Country Neurology, PC, accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to North Country Neurology, PC, if possible or otherwise to me.

OTHER INSURANCE: I understand that North Country Neurology, PC, contracts with health care service plans. The undersigned agrees that I am individually obligated to pay the full charges at the time of service of all services rendered to me by North Country Neurology, PC, if I belong to a plan that North Country Neurology, PC, does not have a contractual agreement.

RELEASE OF INFORMATION: North Country Neurology, PC, may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness,

communicable disease, or HIV, to any person or corporation for any of the following purposes, as each are discussed in more detail in North Country Neurology, PC, Notice of Privacy Practices: (1) payment matters, including reimbursement to North Country Neurology, PC, for services rendered, (2) treatment and continued patient care, and (3) health care operations. North Country Neurology, PC, may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. I have the right to request restrictions on the uses and disclosures of my protected health information; however, North Country Neurology, PC, is not required to agree to such request. I have the right to revoke this consent in writing at any time; however, such revocation shall not affect any prior uses and/or disclosures made by North Country Neurology, PC. I am aware that I have the right to review the Notice of Privacy Practices, and that the same may be amended from time to time. In the event of such amendment, I am entitled to a copy of updated Notice of Privacy Practices, which shall be made available to me at all office locations. A copy of this consent/authorization may be used in place of the original.

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Beneficiary (Patient) Name (print)

____ ________________________________
Beneficiary (Patient) Signature or Authorized Party Date

<u>NOTICE OF PRIVACY PRACTICES:</u> I have been offered/presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. <u>Only need to sign once at first appointment.</u>

Signed:____ Date: __________________________

Relationship to Patient: ____

If patient's representative refuses to sign acknowledgement please document date and time notice was presented to patient and sign:

Presented on: ________________________ at ______________ By: __________________________________