Epilepsy Institute of North Carolina Policy Rev. 11/2013

FINANCIAL POLICY

The *Epilepsy Institute of North Carolina* is a 501(c)(3) Non-profit Organization. We operate on donated funds and the finances generated by our patient base. *We are dedicated to providing the best possible care for you, and need you to completely understand our financial policies*.

Review carefully and *initial on the blank*:

1. Payment is due at the time of service unless arrangements have been made in advance. We accept ***cash, checks, Visa*** and ***MasterCard***. All co-payments *and* balances are due at check in. _____

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. Therefore, as a service to you, we will file your insurance claim if you agree to assign the benefits to the doctor/therapist. In other words, you agree to have your insurance company pay the doctor/therapist directly. If your insurance company does not pay the *Epilepsy Institute of North Carolina* within a reasonable period, we will seek payment from you. If we receive payment from your insurer, we will then refund any overpayment to you. _____

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are *required* to pay a co-payment at the time of your visit. _____

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. *Therefore*, our charges for your care are due at the time of service and you will be reimbursed by your plan. _____

5. Not all insurance plans cover all services we provide. In the event your insurance plan determines a service is "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. _____

6. We will bill your insurance company for all services provided at the Epilepsy Institute of North Carolina except: *forms, medical record copy charges, prescription assistance,* or *other non-insurance billable items*. ***You are responsible for any balance due***. _____

I have read and understand the *Epilepsy Institute of North Carolina's* financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the *Epilepsy Institute of North Carolina* from time to time.

Date: ____/____/20____ Chart # _____

Print name of patient _____

Signature of patient (or responsible party, if minor) _____