**Neuroscience Associates of Kansas City, LLC**
**Robert M. Beatty, M.D. F.A.C.S.**

Patient Name _____

Date of Birth _____

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

_____ 1. **Patient With Insurance including Medicare**
You are responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front-desk staff to make other arrangements. A fee of $30.00 will be charged for any returned checks.

_____ 2. **Worker's Compensation Patient**
As a Worker's Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for balance.

_____ 3. **Personal Injury (Accident)**
If you are a personal-injury patient, our office will bill the insurance companies. The charges for the services rendered will be your responsibility. This amount must be paid prior to each visit. If an attorney is involved and asks you not to submit insurance claims, a doctors lien must be signed by you and your attorney.

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_____ 1. **Minor Patients**
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

_____ 2. **Missed Appointments**
In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee for any appointments not canceled at least one day prior. Please call us as early as possible if you know you will need to reschedule your appointment.

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## ASSIGNMENT

_____ I request that payment of authorized Medicare benefits be made either to me or on my behalf to Neurosurgery of Kansas City for service furnished me by that provider. Medicare Number_____

_____ The signature below authorizes payment of mandated Medigap benefits to Neurosurgery of Kansas City.
Medigap_____Policy Number_____Group Number_____

_____ I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to.

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## RELEASE OF INFORMATION

_____ I authorize Neurosurgery of Kansas City to release to my insurance carrier(s) and/or CMS (formerly HCFA) and its agents and/or my Medigap insurer any information needed to determine benefits or benefits payable for related services.

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I have read and understand the Financial Policy, Assignment, and Release of Information paragraphs stated above that apply to me and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X _____

Patient or responsible party signature Date

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Person signing on behalf of patient (print name) Reason patient can't sign

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Relationship to Patient Address Phone

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