Neurology, Sleep & Pulmonary Specialists

Rajiv B. Nanavaty, M.D.
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FINANCIAL POLICY - Effective 12/01/2019

Our Physicians participate with most HMO's, PPO's and other health insurance plans. Each insurance plan has unique rules and regulations that must be followed by patients and physicians. Please familiarize yourself with the particular benefits and rules of your healthcare plan.

If we are not a participating Provider with your insurance plan, you will be responsible for payment in full at time of service.

Payment - All co-payments and deductibles are due at time of visit, as well as any balance due.

Referrals - Certain health insurance plans require that you obtain a referral from your Primary Care Physician before visiting a specialist's office. It is the patient's responsibility to acquire this referral. Alternative payment arrangements or rescheduling of your appointment may be necessary if proper authorization is not obtained.

Self Pay - Payment in full is expected at time of service.

Returned Check Fee - We charge a **$35.00** fee for all returned checks.

No Show / Cancellation Policy - We charge $50.00 for missed appointments (including EEG, EMG and other in-office testing) if you fail to cancel your appointment within 48 hours or less. If you need to reschedule an appointment, please call us at least 48 hours prior to the appointment to avoid the cancellation fee.

Financial Agreement - I have read, understand and agree to this financial policy. I understand that I am financially responsible for all charges incurred by me for services rendered by Neurology Associates of Suffolk, PLLC, d/b/a NEUROLOGY, SLEEP & PULMONARY SPECIALISTS, whether or not these services are covered by insurance, including all costs incurred to collect delinquent charges, as well as collection agency, attorney's fees and court costs plus interest from the date of service.

PATIENT'S NAME: _____

_____ _____

Signature of Patient/Guarantor Date

Assignment of Benefits / Authorization to Release Medical Records - I hereby authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Neurology Associates of Suffolk, PLLC, d/b/a NEUROLOGY, SLEEP & PULMONARY SPECIALISTS.

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Signature of Patient/Guarantor Date