Orlando Epilepsy Center

Patient Financial Policy Agreement

Thank you for choosing Orlando Epilepsy Center as your healthcare provider. We are committed to your treatment being successful and we appreciate your trust in us. The following statement of our Financial Policy, which you are required to read and sign. Our staff will address any questions that you may have; however, you will need to agree to and sign prior to your treatment being rendered.

- **Self-Pay Patients**: Payments in full is due at the time of service.
- **Patients with Insurance**: We will file your insurance claim for you. However, in order to work with your company, we must have complete and current information, a copy of your insurance card and your signature on file.
- **Insurance Benefits:** It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions that you may have regarding coverage of specialty services.
- **Co-Payments, Co-insurances and Deductibles**: All patient balances are due at the time of service. We accept cash, check, credit cards (Visa, MasterCard, American Express, Discover, and Care Credit).
- **Non-Covered Charges:** Please understand there may be some charges for our services which you insurance company considers *non-covered* and may be excluded from your policy. Accordingly, you will be responsible for these charges.
- **Denied Claims:** Failure to present your current insurance information prior to services being rendered may result in denial of your claim and subsequent billing for unpaid services.
  - You are responsible for any charges that are denied by your insurance company.
- **Medicare**: We are participating Medicare provider. We will bill Medicare, for you, as well as any secondary insurance that you may have. However, that does not mean that all services are covered. Additionally, you are responsible for any co-payments, usually 20% of the allowed amount, as well as any unmet annual deductible. Medicare may allow a service but your secondary insurance provider may not; therefore, you will be responsible for that portion of the bill.
- **Missed Appointments**:
  There is a $25.00 fee for all missed/cancelled **established Patient** office visit with less than 24-hour notice.
  There is a $50.00 fee for all missed/cancelled **NEW Patient** office visit with less than a 24-hour notice.
  NOTE: This is an internal charge and cannot be billed to your insurance company.
- **Returned Checks**: Any returned check is subject to a $25.00 bank fee.
- **Special Financial Arrangements**: We offer monthly payment plans with balances to be paid off in 4 consecutive payments. In addition, we offer financial hardship discounts but these require the patient to complete a Financial Evaluation Form with proper supporting documentation that documents the patient's income.
- **Past Due Accounts**: All past due accounts are subject to collection proceedings. All fees, including, but not limited to the maximum interest that is allowable by law, a 35% collection agency fee and awarded court fees will become your responsibility in addition to the patient balance should you placed with an external collection agency.

I have read, understand, and agree to the above Financial Policy.

______________________________ ______________________________
Signature of Patient or Financially Responsible Person Date

____
Print Name

09/2020bv