WEST TN NEUROLOGY

Ph: 901 213 4225, Fax: 901 213 4226
info@westtnneurology.net
6570 Stage Rd #202, Bartlett, TN 38134

FINANCIAL POLICY

Thank you for choosing West Tennessee Neurology for your healthcare needs. We are committed to providing you with the best possible medical care. To achieve this goal, we have established our financial policy as follows:

Insurance
It is the patient's responsibility to provide current and accurate insurance information at each visit. We will bill your insurance company for services rendered as a courtesy. If your insurance company does not respond or pay within a reasonable time (60 days), you will be expected to follow up with your insurance company. You are ultimately responsible for the payment of all services. Co-payments, deductibles, and non-covered services are due at the time of service. We accept most major insurance plans, and it is the patient's responsibility to understand their coverage and benefits, including referral and preauthorization requirements. Should a patient's health plan determine a service as "non-covered," the patient will be responsible for the complete charge.

Pre-authorization/Pre-certification: Some insurance companies require pre-certification/pre-authorization. We will gladly assist you in meeting these requirements when requested, however, the responsibility is yours to ensure that any such requirements are complete prior to the treatment. If pre-certification/pre-authorization is required, and not completed, you will be responsible for all denied charges.

Payments: All co-payments, coinsurances, deductibles and fees are due in full at the time of service. As a courtesy, we will file your insurance claim for you. If your insurance company does not respond or pay within a reasonable length of time (60 days), you will be expected to follow up with your insurance company. In that case, you are responsible for any amount that your insurance does not pay within the 60-day period.

Updated Insurance and Account Information: It is your responsibility to inform us of any changes on your or your child's account regarding insurance or address information. Acceptable insurance identification is required if there is a change in insurance companies or insurance coverage. We will require to keep a scanned copy of your new insurance card once you receive it.

Cancellations and No-show Fees: There is a $50 charge for cancellations and rescheduling less than 24 hours from appointment time, and for no-shows to appointments that were not cancelled or rescheduled. An appointment missed by one, is an appointment missed by two as someone else could have used that appointment. We will see patients who are no later than 15 minutes late. Patients arriving later than 10 minutes will be triaged for severity of complaints and be accommodated accordingly. It is best to call and let us know if you are going to be late.

Credit Card on File: West Tennessee Neurology requires an active and unexpired credit card to be kept on file at all times. The credit card will be used for payments for medical services rendered, for account balances, and for cancellation, late rescheduling, and no-show fees charged as per our policy. This credit card on file will only be used if your balance is not paid in full in 120 days. You will also need to sign a patient payment consent form. You will be notified in writing of any charges made to your credit card. The credit card information will be securely filed in an encrypted format to prevent theft.

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Returned Checks: Checks returned and payments refused for insufficient funds will be charged $50 service fee.

If You Do Not Have Insurance: A minimum deposit of $150 for established patients and $250 for new patients or the actual charges, whichever is less, is due at the time of the service for all self-pay patients. Any subsequent visit charges will be due at time of service. If you cannot pay in full, we will advise to set up a payment plan by speaking to someone in the billing office. The parent or guardian accompanying the patient is responsible for payments.

Collections: It is our policy that our past due accounts will be sent two statements, and thereafter one phone call will be made to try to make payment arrangements. If payments are not made to the patient account, the account will be sent to the collection agency. Please note that after your balance has been sent to collection, you may be dismissed as a patient in our clinic. Your balance will need to be paid at our collection agency in full prior to receiving services in our clinic. In the event that your account is placed with a collection agency, a collection fee of up to 33.3% may be added to your account and shall become a part of the total amount due. You will be responsible for any and all cost of collection including attorney fees and court costs. The practice will do its best to work with our families to meet payment obligations.

Self-Pay Patients
Patients without insurance coverage are considered self-pay. Payment is due at the time of service unless other arrangements have been made in advance with our billing department. We may offer a discount for self-pay patients; please inquire with our billing department for details.

Payment Methods
We accept cash, debit cards, and major credit cards. We do not accept personal checks.

Outstanding Balances
Patients with an outstanding balance will receive statements. Payment is due upon receipt of the statement. If the balance remains unpaid, we may take further action, including sending the account to a collection agency.

Changes to Financial Policy
West Tennessee Neurology reserves the right to change the financial policy anytime. Changes will be communicated through updated policy statements.

Acknowledgment
By signing below, you acknowledge that you have read, understand, and agree to the West Tennessee Neurology Financial Policy. You also authorize your insurance benefits to be paid directly to West Tennessee Neurology, recognizing that you are financially responsible for non-covered services.

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ACKNOWLEDGEMENT

I have reviewed the Financial Policy of West Tennessee Neurology and agree to all its terms.

Patient or Legal Guardian Name:

Date: _____