United Neuroscience, Inc.

9330 Stockdale Highway, Suite 200, Bakersfield, CA. 93311, United States.

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS & MISSED APPOINTMENTS

Patient Name: _____ Date of Birth: _____

Date: _____

Financial Agreement

Thank you for choosing our practice for your healthcare needs. We are committed to providing you with quality medical care. This agreement outlines your financial responsibilities.

Insurance

As a courtesy, we will submit claims to your insurance carrier when appropriate. Verification of insurance benefits is not a guarantee of payment. Your insurance policy is a contract between you and your insurance company.

You are responsible for:

- All applicable copayments, coinsurance, deductibles, and non-covered services.
- Charges denied by your insurance carrier due to eligibility issues, lack of authorization (when required by your health plan), non-covered services, benefit limitations, or failure to comply with your policy requirements.
- Any balance remaining after your insurance carrier has processed your claim, unless prohibited by law or your provider's contract with your health plan.

Payment is expected at the time services are rendered unless prior payment arrangements have been approved.

Self-Pay Patients

Patients without insurance or those choosing not to bill insurance are responsible for payment in full at the time of service unless other arrangements have been made.

Returned Checks

A fee of $25.00 may be assessed for returned checks or rejected electronic payments, as permitted by applicable law.

Past Due Accounts

Balances not paid within 60 days of the first billing statement may be subject to collection efforts. If your account is referred to a collection agency or attorney, you may be responsible for any costs of collection to the extent permitted by law.

Missed Appointments

A fee of **$50.00** may be charged for appointments that are missed or cancelled without **at least 24 hours'** notice, to the extent permitted by applicable law and your insurance contract. Patients who **no-show two (2) times within a 12-month** period may lose their ability to schedule future appointments with our office.

Medical Records and Forms

Fees for copies of medical records will be charged in accordance with applicable California law.

Fees may also apply for completion of forms, disability paperwork, FMLA forms, or other administrative requests that are not covered by insurance, when permitted by law. Patients will be notified of any applicable fees before services are performed.

Assignment of Benefits

I hereby authorize payment of my medical benefits directly to the above-named practice for services provided to me or my dependents.

I assign to the practice all medical and/or surgical benefits, including major medical benefits, private insurance, Medicare, Medicaid/Medi-Cal (where assignment is permitted), and any other health plan benefits payable for services rendered.

This assignment will remain in effect until revoked by me in writing, unless otherwise prohibited by law.

I authorize the practice to release medical and other information necessary to process insurance claims, obtain payment, or coordinate my healthcare, consistent with applicable federal and state privacy laws.

I understand that if my insurance carrier sends payment directly to me for services rendered by this practice, I am responsible for immediately forwarding such payment to the practice.

I understand that I remain financially responsible for all charges not paid by my insurance carrier, except where prohibited by law or by the provider's participation agreement with my health plan.

Patient Acknowledgment

I have read and understand this Financial Agreement and Assignment of Benefits. I have had the opportunity to ask questions regarding my financial responsibilities.

I agree to comply with the policies outlined above.

Patient/Responsible Party Signature: _____

9330 Stockdale Highway, Suite 200, Bakersfield, CA. 93311, United States.

Email: UNI@unitedneuroscience.org **www.unitedneuroscience.org**

Phone: 661-324-0500. Fax: 661-324-0600

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____

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