CAPITAL NEUROLOGY
4250 CRUMS MILL ROAD STE 102
HARRISBURG, PA 17112-2889
(717) 649-0211

PATIENT INSURANCE RESPONSIBILITY AGREEMENT

We welcome you as our patient and appreciate the opportunity to provide you with medical care. We are committed to providing you with timely and quality health care. Because many of our patients have questions regarding patient and insurance responsibility for the services rendered here, we have this policy available to assist you. Please read it, ask any questions you may have, and sign in the space provided. A copy can be provided to you, upon request.

1. **Insurance**: We participate in most plans, including Medicare. Knowing your insurance benefits is your responsibility. Please be sure to contact your insurance company with any questions you may have regarding your coverage. If you are not insured by a plan we do business with, be aware that you will be billed for all services provided.
2. **Proof of insurance and/or identity**: We must obtain a copy of your insurance card and photo ID. Each time you visit our office, you will be asked to show your business card and a photo ID.
3. **Non-covered**: Please be aware that some of the services received at our office may not be covered by your insurance. You are responsible for any balances not covered by your insurance plan. If you receive any durable medical equipment (including, but not limited to, casting and bracing) you may receive a bill for those non-covered items from the durable medical equipment provider.
4. **Coverage changes**: If your insurance changes, it is your responsibility to notify us prior to your visit, in order for us to make the appropriate changes so you can receive the maximum benefits.
5. **Co-payments and deductibles**: All co-payments and deductibles must be paid at time of service. We accept cash, check, credit card, as well as debit cards.
6. **Claims submission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid by the insurance company. Your insurance company may require you to provide certain information directly, before claims will be paid. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Your contract includes payment of co-pays and deductibles.
7. **Missed appointments and late arrivals**: Your may be charged a fee for a missed appointment that has not been canceled within 24 hours. The no-show charge for a regular appointment is $25.00. These charges will be your responsibility and billed directly to you. Please help us serve all patients by arriving on time. If you arrive 15 minutes late for a scheduled appointment, we may need to reschedule your appointment.
8. **Diagnostic services**: If the physician orders diagnostic services, such as an X-ray, this service can be [provided on site for your convenience. This service will be billed separately by Capital Neurology.
9. **Medication refills**: We require 24 hour notice for medication refills.
10. **Form completion**: There is a self-pay fee for completion of all forms due upon receipt.
11. **Litigation services**: Please note that our office does not provide litigation services.

Please let us know if you have any questions or concerns.

SIGN: I have read and understand the payment policy. I agree to abide by its guidelines.

Name of patient	MRN#	Date of birth
Signature of patient/responsible party	Relationship (if applicable)	Today's date