Neurology Associates Northwest
Patient Financial Responsibility

Thank you for choosing Neurology Associates Northwest as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understand of our patient financial policies.

Patient Financial Responsibilities:

- The patient [or patient's guardian, if a minor] is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copayments are due at the time of service.
- Coinsurance, deductibles and non-covered services are due 30 days from receipt of billing.
- Patients may incur and are responsible for payment of additional charges if, applicable. These charges may include:
    - Charge for returned checks
    - Charge for missed appointments without 24 hours' notice
- By my signature below, I hereby authorize assignment of financial benefits directly to Neurology Associates Northwest [Christopher J Ginocchio MD, Beenish K Khwaja DO, Elizabeth A North DO & Kirk L Weller MD]
- By my signature below, I authorize Neurology Associates Northwest [Christopher J Ginocchio MD, Beenish K Khwaja DO, Elizabeth A North DO & Kirk L Weller MD] personnel to communication by mail, phone and/or voice mail message, according to the information I have provided below:

Please read and then choose YES or NO:

- If you are unavailable, may we leave medical information from Neurology Associates Northwest [Christopher J Ginocchio MD, Beenish K Khwaja DO, Elizabeth A North DO & Kirk L Weller MD] office, such as normal blood test results or normal biopsy reports on your voice mail or with someone at your residence?

  ☐Yes – you may leave information as above
  ☐No – do not leave any information with anyone

If yes, please list name and relationship of person(s) we are authorized to discuss your medical care/or account:

_____ _____

Name Relationship Name Relationship

I have read, understand and agree to the provisions of this patient financial responsibility form:

_____ _____

Signature of Patient or Guardian Date