



Neurosurgical Specialists, Inc.  
6261 E. Virginia Beach Blvd.  
Suite 200  
Norfolk, VA 23502

## Payment Policy Effective 04/02/2014

Thank you for choosing our practice for your care. We are committed to providing you with quality and affordable health care. To avoid misunderstandings with the staff and patients we have developed a new payment policy. Please read the policy and ask any questions you may have. Sign in the space provided and return to the Receptionist and the document will become part of your record. A copy will be provided to you upon request.

1. **PAYMENT IS DUE AT TIME OF SERVICE.** This includes Co-pays, Deductibles, percentages due and non-covered charges. Failure to comply with this policy will result in rescheduling your appointment for another date.
  - a. For the patients convenience our office accepts **cash, check or Visa, MasterCard and Discover.**
  - b. A **\$30.00** service fee will be charged for all returned checks
2. **Participation with Insurance.** We participate with most insurance companies including Medicare. We do not participate with Aetna and United Healthcare, however we can still care for you if you have **OUT OF NETWORK BENEFITS**. Knowing your insurance benefits is your responsibility. If you have questions regarding your coverage, please contact your insurance company.
3. **Proof of Insurance.** All patients must complete our patient information form prior to seeing the doctor. Our **PATIENT PORTAL** is available 24 hours if you have access to a computer and this can be done prior to your visit. If you do not have a computer it can be done upon arrival before seeing the doctor. We must obtain a copy of your driver's license and a current valid insurance card. If you are unable to provide proof of insurance you will be considered Self Pay and payment in full will be expected.
4. **Coverage Changes.** Please contact our office prior to your next visit should you have changes in your coverage. Our **Patient Portal** is available 24 hours for your convenience to update your information or, if you do not have access to a computer you should call our office.
5. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of the 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 and NSI is not a party to that contract.
6. **Cancellations and Missed Appointments.** If you fail to show up for your appointment and do not cancel within a reasonable amount of time to fill the appointment you will be charged a **\$50.00 fee** that will be billed directly to you. Appointments should be cancelled 24 hours prior to appointment time.
7. **Litigation.** If your treatment is being covered through litigation with an attorney involved it is our policy to have a **Lien Letter** on file. The letter must be signed by you and your attorney to continue care past your first visit.
8. **Referral Letter of Understanding.** I understand that if I am seeing a physician at Neurosurgical Specialists Inc. without the benefit of a valid referral as required by my insurance carrier, I may be responsible for full or partial payment for any charges resulting from this visit and/or any diagnostic testing that may occur. I understand that retroactive referrals are not allowed as the normal rule under my insurance referral policy and that any referrals produced after this form is signed may or may not be considered valid for payment of my medical care. By signing below, I hereby accept the risk and wish to complete this visit.

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

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_