South Coast Neurology Inc.

FINANCIAL RESPONSIBILITY AGREEMENT

I accept full financial responsibility for medical expenses incurred at the **South Coast Neurology, Inc.**

I understand that I am responsible for the following possible charges:

- If I fail to call and cancel/re-schedule at least 48 business hours prior to any scheduled appointment for regular care that I am unable to show up for, a $40.00 fee will be assessed.
- All payment for services rendered are due at time of service; if they are not paid, a $10.00 billing fee will be assessed to your account.
- If payments are not received within thirty (30) days of the original billing, a $10.00 re-billing fee will be assessed.
- Any checks returned from my financial institution will have a $40.00 fee assessed.
- Any card that is declined is subject to a $40.00 fee, regardless of the balance as well as late fees that apply to an overdue balance
- A late fee of $15.00 will be assessed every 90 days after the initial billing date and will be assessed an 18% APR fee every 90 days after the initial billing date.
- These amounts must be paid in full prior to any further service provided by our office.
- If I fail to call and cancel/re-schedule at least 48 business hours prior to any scheduled appointment for a Neurodiagnostic Testing, a $200 fee will be assessed.

➡ ***Patient's Initial (Seal)***

It is my responsibility to inform **South Coast Neurology, Inc.** if I am working with a third party payer in reference to my condition i.e. workers' compensation and legal counsel. Failure to do so prior to service being rendered will cause all costs associated with my care to be my personal responsibility.

If claims filed by **South Coast Neurology, Inc.** to my insurance company or any other third party are denied, I will cooperate with the billing department of **South Coast Neurology, Inc.** to ensure payment for my services. I understand that I will be legally responsible for all costs associated with the collection of my account, including collection fees, if I default on this agreement.

➡ _____ _____

Signature (Seal) **Witness Signature**

➡ _____ ➡ _____

Print Name **Date**

➡ _____ ➡ _____

Primary Insurance **Plan Insurance Address**

Credit Cart on File Agreement

I authorize South Coast Neurology, Inc. to charge co-insurance, no-show fees, outstanding balances, and/or any charge for services rendered at 1919 State Street #203 Santa Barbara CA 93101

In our efforts to improve patient service and office efficiency, we have implemented a policy which enables you to maintain your credit card information securely on file with South Coast Neurology, Inc. In providing us with your credit card information and signing this form, you are giving SCN, permission to automatically charge your credit card on file for your deductible, co-insurance, no-show fee, or outstanding patient balance TWO WEEKS after insurance has adjudicated your claim. As a courtesy, you will be sent a billing statement when a balance becomes due.

□ HSA/FSA □ Visa □ MC □ Discover □ Amex □ Debit

Credit Card Holder's Name (print):
_____

CC Number:
_____

Exp Date _____/_____ Zip Code _____ CVV _____

What if I have a debit card or HSA? How will I know exactly when the charge will be put through?

You are notified by your insurance company of any patient portion due by you. We also send you a statement after which you have TWO WEEKS to review and pay your balance with your preferred payment. If we do not hear from you within the two weeks, we assume you are in agreement with your balance and prefer we use your credit card on file. If you would like a credit card receipt, you are welcome to call our office and request it within 60 days of the charge.

This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. We recommend you contact your insurance company first with any insurance discrepancies.

DECLINED CARD: Any card that is declined is subject to a $40.00 fee, regardless of the balance as well as late fees that apply to an overdue balance. It is my responsibility to make sure the card on file is valid and accurate. I will notify South Coast Neurology; as soon as, possible with any card information changes. In the event that there are any
problems with my credit card payment, I agree to pay all collection costs and reasonable attorney's fees incurred in attempting to collect on the account balance.

I certify that this is my credit card and that I am legally authorized to give permission for its use by South Coast Neurology, Inc for my
balances on my account.

SIGNATURE: _____ Date: _____