NeuroZone

Financial Policy

As an “out of network” provider the services you received at Neurozone Inc. may not be covered or only partially covered by your insurance policy. We do our best to provide you with accurate policy coverage information prior to starting our program so that you are aware of your out of pocket costs in advance.

Neurozone Inc. agrees to accept the contracted rate, set forth by your insurance company, for services rendered. As a client of Neurozone, you will not be financially responsible for any balances incurred for services that are either not covered or only partially covered by your insurance policy.

In most cases, we will charge a nominal fee for your treatment. This fee will be disclosed to you prior to conducting any treatment.

By signing this form, you agree to pay these additional fees according to the fee schedule presented for services not covered by your insurance company.

Neurozone Inc. will submit claims to your health insurance company on your behalf after services have been rendered. **This form certifies that when Neurozone Inc. submits insurance for their client that the reimbursement will be issued to NZ ____ (Initial here).**

____ (Initial here) If Neurozone Inc. bills the insurance directly for payment of services and the insurance does not cover said services, the client will be financially responsible for the services rendered to Neurozone Inc. as per the financial agreement between client and Neurozone Inc.

Authorization of Benefits

It is your responsibility to provide accurate insurance information (front and back insurance card and driver’s license) to NZ at the time of service. NZ will create and submit claims to your health insurance company on your behalf.

___ (Initial here) This is a direct assignment of my rights and benefits under this policy. I hereby request that all health insurance plan benefits be made on my behalf to NZ for the services provided.

This authorization shall be considered valid for the duration of the claim. A photocopy of this authorization will be considered as effective and valid as the original. Your signature on this policy authorizes Neurozone Inc. to release health information to insurance carriers when necessary for payment, and directs them to remit payment directly to Neurozone Inc.

Notice of Insurance Billing Practices

Neurozone Inc. is not contracted with any insurance companies or managed care organization and services rendered are done so “out of network”, as a non-preferred provider. Our contract is with you and/or the guarantor, not your insurance company. As such, the financial guarantor is

NeuroZone

responsible for all cost of treatment not covered by insurance as per the financial agreement between client and Neurozone Inc. We strongly envourage all families/guarantors to contact their insurance companies to learn about specific benefit coverage, limitations, and criteria for medical necessity prior to admission.

Neurozone Inc. does not accept full assignment of benefits and cannot provide treatment based solely on the hopes that your insurance will pay for care.

I acknowledge receipt of this notice and agree to the terms contained herein.

________________________________ ____________________

Responsible Party Date

_______________________________ ____________________

Client Date