NEUROLOGIQUE FOUNDATION, INC.

FINANCIAL AGREEMENT

PATIENT INFORMATION

PATIENT'S NAME _____
Last First M.I.

ADDRESS _____

BIRTHDATE _____/_____/_____ **DAYTIME TELEPHONE NUMBER** _____
Month Day Year

SOCIAL SECURITY NO. _____

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have received a copy of **Neurologique Foundation, Inc.'s ("Neurologique")** Privacy Notice dated _____ ("Notice"). I understand that I am responsible to read this Notice and notify Neurologique, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. Neurologique has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times. Neurologique will provide me with a copy of its most recent Notice upon my request.

Date: _____

Patient Signature: _____

Parent, Guardian or Legal Representative Signature: _____

Witness Signature: _____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Neurologique. I understand that payment to Neurologique is not contingent on any insurance, settlement or judgment payment. I further understand that such payment is not contingent on the results of any treatment. Neurologique does not refund any payment for services rendered. Neurologique will not file a claim for payment with my insurance plan. I will be responsible for prompt payment of all amounts owed to Neurologique. I will receive a statement once a month, if I have a balance owing. Failure to pay a balance by the third billing statement will result in my account being turned over to the collection process. **SHOULD MY ACCOUNT BE REFERRED TO A COLLECTION AGENCY OR ATTORNEY FOR COLLECTION, THEN I WILL PAY ALL COSTS OF COLLECTION, INCLUDING A REASONABLE ATTORNEY'S FEE.**

PAYMENT OPTIONS

I understand that I may pay for my services by cash or check. If my check is returned for non-payment due to insufficient funds or a closed account, Neurologique will charge me a $25.00 fee. This fee is in addition to any fees that may be assessed by my bank for returned checks.

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AUTHORIZATION AND RELEASE OF INFORMATION FOR TREATMENT

I hereby authorize Neurologique to discuss my care with and release any medical or other information necessary to my primary care and/or specialist physicians for my treatment.

APPOINTMENTS AND CANCELLATION POLICY

I understand that it is essential, that all appointments be kept promptly. When I cannot keep an appointment, I understand that Neurologique must be notified at least twenty-four (24) hours in advance to cancel or reschedule an appointment. If I do not call 24 hours in advance of a cancelled appointment, a $25.00 fee will be charged. Neurologique understands that emergencies do arise. In the event of an emergency, I understand I must notify Neurologique as soon as possible if I cannot keep my appointment so that other patients in need of care can be seen. If I miss two (2) scheduled appointments, I understand that I may be dismissed as a patient from Neurologique.

COMPLETION OF FORMS

I understand there is a charge of $25.00 for the completion of disability, FMLA, or leave of absence forms. I must complete the patient information sections completely and sign the form prior to submission to Neurologique. Neurologique requires ten (10) business days from the date the form is received by Neurologique for completion.

CONSENT FOR TREATMENT

I give my consent to Neurologique to provide medical care, diagnostic testing and treatment to the below named patient deemed medically necessary and proper in diagnosing or treating my physical condition.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Parent, Guardian or Legal Representative Signature:_____

Printed Name of Parent, Guardian or Legal Representative:_____

Relationship to Patient:_____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate, etc.): _____

Witness Signature:_____