# Acknowledgement of Financial Responsibility

**I acknowledge that if GINSBURG NEUROLOGY, PLLC is not a contracted provider for my primary OR secondary insurance, I will be charged the cash-pay price, payable in full, prior to my appointment.**

I acknowledge as a courtesy; **GINSBURG NEUROLOGY WILL ONLY BILL OUT OF NETWORK SECONDARY INSURANCE IF MEDICARE IS PRIMARY FOR ME**. If payment is received on my behalf, GINSBURG NEUROLOGY will reimburse me for the payment received.

I acknowledge that I am FULLY RESPONSIBLE for charges not paid by my insurance(s), or other agency(ies). This includes, but is not limited to co-pays, co-insurance and total balances. I acknowledge that GINSBURG NEUROLOGY will mail to my address on file a total of three (3) statements requesting payment. If payment in full has not been made, or a payment plan has not been set up by the due date, I acknowledge that my account will be turned over to collections and I will be responsible for all associated costs.

GINSBURG NEUROLOGY accepts checks, Visa, Mastercard and debit cards. Discover and American Express are not accepted. There is an additional $30.00 fee for returned checks, which will be added to any existing balance.

**I acknowledge that I will be charged a $50.00 rescheduling fee for office appointments not cancelled at least 24-hours of appointment time and/or for same day cancellations. This fee will be collected prior to rescheduling my appointment. A $300.00 fee will be assessed for "NO SHOW" for procedure/testing appointments not cancelled at least three (3) business days of scheduled appointment time. This fee will be collected prior to rescheduling my appointment.**

By signing below, I acknowledged receipt of, and agreement to this practice's patient financial responsibility policy.

Signature of Patient: ______________________________________________________________

Printed Name of Patient: ___________________________________________________________

Date of Signature: _________________________________________________________________