Sandia Neurology PC Privacy and Payment Policy Overview 2019

I consent to receive medical care and treatment as deemed necessary or advisable in the judgement of Dr. Sally Harris which may include testing, outside consultation, treatments, and or follow up exams. I understand I will be informed about my condition and recommended diagnostic or medical procedures to allow me to help make the best decisions for treatment. This consent allows Dr. Harris to perform reasonable and necessary medical examinations, testing, and treatment. This consent remains in effect until it is revoked in writing. I authorize SNP to share part or all of my medical record to outside medical providers, insurance companies, disability determination, legal representative, or workman's comp carriers unless I specifically indicate otherwise.

As long as Dr. Harris is IN my medical insurance network, I agree to provide accurate and complete insurance and personal id at every visit or else pay the standard fee at the time of my visit. It is my responsibility to understand the benefits provided by my insurance plan. If I use insurance, I hereby assign all medical insurance benefits to which I am entitled to Sandia Neurology PC (SNP). I also authorize SNP to submit any and all appeals if my insurance denies benefits. I understand that I may leave a valid credit card on file to be used and avoid all late fees and collections fees. I may choose to allow SNP to run the card when needed.

I agree to pay in full any balance not covered by my insurance which may include any no show fees, form fees, or failed appeals. I understand that I am responsible for NM gross receipts tax on payments other than charges from NM based plans. I will pay copay and estimated payment at time of the visit OR I will leave a valid credit card on file with the office. I understand that I may review the full privacy practice policy for a more complete description of my protected health information and the use thereof.

I agree to pay a fee of $75 for missing a follow up appointment or giving less than 1 business day cancellation notice, or $150 for missing a procedure or new patient visit that I scheduled and did not cancel at least 2 business days in advance I understand that after my insurance has paid their specified reimbursement to SNP, I will be called to inform me and given the options of payment (credit card, check, cash). I will have 30 days from the date of the visit to pay in full or set up a payment plan
I understand that I may set up a payment plan with a credit card on file only. Only written payment plans are considered active. After 30 days of nonpayment a $20 fee will be added to my bill and sent to third party assistance. After 60 days of nonpayment, my account will be sent to collections, the fee will be updated to be either $35.00 or 35% or the amount due, whichever is greater. I will not be rescheduled or be allowed to obtain refills until my outstanding balance is paid or a payment plan has been initiated.

Printed Name _____ Signature _____

Date ____/____/_____ SNP Witness _____

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