Cocheco Neurology

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Financial Disclosure

Welcome to our practice. We are committed to giving you the best medical care. In return, we expect that you have the same commitment to your medical care and your financial responsibility associated with this care.

As a courtesy, Cocheco Neurology Professional LLC, will file your insurance claim; however, it is your responsibility to know your insurance company's requirements. Please verify with your insurance company that the doctor you are scheduled to see is participating with your insurance. We accept cash, checks, and credit cards (Visa, MasterCard, and Discover). A $25.00 service charge is assessed for all returned checks. Any accounts not paid in full within 60 days of your first statement may be considered for collections and subject to applicable fees.

CONTRACTED HMOs and PPOs: You are responsible for any applicable deductibles or co-insurance amounts. Co-payments are due at the time of service. Services not covered by your plan will be billed to you. Referrals are your responsibility. If a referral is not in place, your appointment will be rescheduled.

INSURANCE WE DO NOT PARTICIPATE WITH: As a courtesy we will file your insurance for you. You are required to pay for each visit in full at the time of service.

SELF PAY: You are required to pay in full at the time of services. If you have any questions, contact our financial office at 603-343-5025.

WORKERS COMPENSATION: If your injury is work-related, we need the carrier name, address, and case number prior to your visit. If you do not provide us with this information, you will be responsible for the charges incurred at the time of service. If this is a Federal worker's compensation claim, please provide us with the Letter of Acceptance at the time of your appointment.

ANCILLARY SERVICES: With the numerous managed care plans and the ever-changing participating providers for radiology, laboratory, surgery centers, physical therapy, and hospitals, it will be your responsibility to know which facility you are required to use. If you are unsure, call your insurance company.

RELEASE OF INFORMATION: I hereby authorize the release of medical records and/or statement of account to my insurance company in order to determine benefits for services rendered.

AUTO: As a courtesy, we will bill your auto insurance for you; however, your auto insurance will not pay us directly. You are required to pay for each visit in full at the time of services.

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment for medical and/or surgical services to Cocheco Neurology PLLC. This authorization will remain in effect until revised by me in writing. A copy of this authorization will be considered valid as the original. I understand I am financially responsibly for all charges, surcharges, and attorney's fee, whether or not they are bad by my insurance. I hereby authorize the above listed provider to release all information necessary to secure payment.

Signature: _____ Date: _____

I have read and I understand the above financial policy. I accept responsibility for all professional fees.

Signature: _____ Date: _____