NEURO INSTITUTE

FINANCIAL AGREEMENT

I, _____________________, understand that in order to receive services at The Neuro Institute, Inc. (“NI”) **I must pay the amount of my co-payment** pursuant to my insurance policy(s) **in the form of cash, check, money order, or by a credit card at the time services are rendered.**

In the event that I:

a) **do not have insurance coverage; or**

b) **have elected to receive services from NI before NI has received prior authorization for the provision of such services from my insurance carrier.**

c) I understand that I will receive a bill for such services on the Monday following the initial date of service.

d) I understand that my failure to render payment in full for the billed services, either prior to or on the fourth (4th) day following the receipt of such bill, may result in NI immediately suspending further services at its sole discretion.

e) I understand that at the sole discretion of NI that services may remain suspended until all amounts due and owing, including charges associated with services that have been rendered but have not yet been billed, are paid in full.

f) I agree that I may pay all amounts outstanding and due in the form of cash, check, money order, or by a credit card. I also agree that the failure to remit timely payment in the correct form shall result in the accrual of interest against all outstanding amounts in an annual amount of fourteen percent (14%).

In the event that I do have insurance coverage I agree to make payment in full for services billed to my insurance carrier by NI that are not paid within thirty (30) days of my receipt of such bill.

a) I understand that NI is billing my insurance carrier solely as a courtesy to me.

b) I understand that it is my sole responsibility to obtain authorization from my insurance carrier prior to the provision of services by NI.

c) I understand that I am financially responsible for the payment of all services to NI in the event my insurance carrier either denies coverage, or otherwise fails to make timely payment on my behalf.

NO ALTERATIONS TO THE TERMS AND CONDITIONS OF THIS AGREEMENT SHALL BE APPLICABLE UNLESS FORMALIZED IN A SEPARATE WRITTEN AGREEMENT MODIFYING SUCH TERMS AND CONDITIONS AND SIGNED BY EACH OF THE RESPECTIVE PARTIES. THIS APPLIES TO ALL ORAL AGREEMENTS OR OTHER AGREEMENTS ENTERED INTO PRIOR TO, OR AFTER THE DATE OF, THIS AGREEMENT.

_________________________________ _________________________________ ___________

Printed Name of Patient or Parent/Guardian Patient or Guardian/Parent Signature Date