THE NEURON CLINIC
PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

The Neuron Clinic makes every attempt to accurately verify patient insurance eligibility and seek approval for treatments and procedures when required by your insurance company. To do this, we communicate with your insurance company both online and over the phone. Insurance verification is a courtesy to patients, and although we attempt to verify your benefits as accurately as possible, your insurance may on occasion determine that the care you received is **not** covered in spite of our eligibility verification and/or prior authorization.

Please, review your insurance benefits guide and when in doubt, contact your insurance directly. It is ultimately your responsibility to understand your benefits and pay for any care that you receive that your insurance does not cover, which may include deductibles, copayments, coinsurances, cost-sharing, noncovered benefits, and other charges.

Some common reasons that insurance may refuse to pay for all of your care are:

- You have a deductible/copayment/coinsurance/cost-share owed
- The care/treatment/drug/procedure is not a covered benefit or only partially covered
- The care/treatment/drug/procedure is not deemed medically necessary
- You visited our office before or after your insurance coverage was active
- The insurance you provided is secondary to your primary insurance, which may include accident or worker compensation coverage

Regardless of the reason your insurance denies to pay the entire balance, it is your responsibility to make payment to The Neuron Clinic for the care that you have received. By signing this consent, you hereby agree that you understand your financial responsibility when seeking medical care and agree to pay for all charges not covered by insurance exhibit when prohibited by law.

Patient Name:_____Date of Birth:_____

Name of Representative:_____Relationship to Patient:_____

Patient/Representative Signature:_____Date:_____