CENTER FOR COMPLEX NEUROLOGY
EDS & POTS

Patient Name:_____ DOB: _____

Financial and Appointment Policy

Please initial each section stating that you have read it and understand it and sign the bottom of the form.

YOU ARE RESPONSIBLE FOR KNOWING YOUR INSURANCE POLICY

AUTHORIZATIONS – Center for Complex Neurology, EDS & POTS is out of network for most health plans. We are not contracted with any AHCCCS network or Medicare Advantage (replacement) plans. As a result, we are OUT of NETWORK for most plans. To be treated at our Center, YOU are responsible for obtaining an OUT OF NETWORK PRIOR AUTHORIZATION from your Primary Care Provider (PCP). If you do not obtain the necessary authorization you will be responsible for payment in full prior to any treatment or visit

If we are in-network with your insurance and your insurance requires a referral/prior authorization from your primary care physician (PCP) for ANY service, it is YOUR responsibility to obtain this prior to your visit. If you do not have the necessary authorization, you will be responsible for payment in full prior to any treatment or visit.

I understand that authorizations are my responsibility. _____

Self-pay or Cash patients – Payment for services are due at the time services are rendered. We do offer a 20% prompt pay discount at the time of service for visits and some treatments.

Insured Patients – All co-pays, co-insurance and deductible amounts are due at the time services are rendered. You will be required to provide your most current insurance card and information at the time of your appointment. Check with your insurance regarding your benefits prior to scheduling any appointments.

Center for Complex Neurology, EDS & POTS prefers credit cards. We do not keep cash on hand. We do accept checks. Please note that returned checks are subject to a $25 fee plus the full amount due for the visit.

I understand that payment is due prior to services being rendered. _____

Statements/Payment Arrangements – As a courtesy, we file your claims for insurance that we are contracted with or for which we have an out of network authorization. We will supply information as necessary; however, we will not get involved in disputes between you and your insurance carrier. This includes but is not limited to disputes regarding deductibles, co-payments or any non-covered charges, usual and customary charges or COBRA issues. If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. All patient responsibility balances are due in full within 30 days from the receipt of your statement. If your account is delinquent after 31 dyas, you may call our billing department to request payment arrangements for balances over $100. Long-term payment arrangements will not be made. All balances must be paid within 90 days.

I understand the payment/statement arrangements policy and that I am ultimately responsible for my bill. _____

Failure to Pay - Delinquent balances (greater than 90 days after initial statement) – In the event that a delinquent account is placed with an outside agency for collections, the responsible party hereby agrees to pay all costs associated with placement, including but not limited to a 25% collection and preparation and transfer fee.

I understand that there will be addition fees if my account has gone to collections. _____

Missed Appointments (no-shows), Late arrivals – While we make every effort to reach our patients via text at least 48 hours prior to your appointment and, when possible via phone, it is your responsibility to remember your appointment. We charge a $35 missed appointment fee to patients who do not keep a scheduled appointment time or who cancel less than 24 hours in advance. A second missed appointment will result in a $60 fee. After 3 missed appointments or last-minute cancellations, the practice may, at its discretion choose to discontinue your care. Any missed appointment fees must be paid prior to scheduling another appointment.

I understand that there are cancellation fees and it is my responsibility to know when my appointment is scheduled._ _____

Missed Scheduled Tests or Treatments – For patients who have a procedure, specialty test or a treatment, there is a $75 cancellation fee for cancellation less than 24 hours.

I understand that there are cancellation fees and it is my responsibility to know when my testing or procedure appointment is scheduled. _____

.Arrival Time: We ask our patients to arrive before the scheduled time of their appointment. If you do not arrive at least 15 minutes prior to your scheduled time, you are considered late. We need this time to ensure that we can have any paperwork and payment information completed and to get you roomed. Dr. Saperstein spends the full appointment time with his patients. As a courtesy to patients who are on time, if you arrive later than we have requested, the patients who did arrive on time may be taken in first and you may have to wait until you can be fit in or rescheduled.

I understand that late arrival may mean I have to wait or be rescheduled at the practice's discretion. _____

Treatment of the Staff - It is the policy of Center for Complex Neurology, EDS & POTS that, just as we strive to treat our patients with respect that you treat our staff the same. At the discretion of the practice, we may decide not to provide care for you if you are rude or abusive to the staff.

I understand that mutual respect is to be maintained. _____

Payment is ALWAYS ultimately the patient's responsibility. Your insurance policy is a contract between you and your insurance company. You are ultimately responsible for the timely payment of your account. If your insurance has not paid within 30 days, you may be held responsible for the charges.

By my signature below, I acknowledge that I have read and understand each item above and agree to and accept Center for Complex Neurology, EDS & POTS' financial and appointment policies.

Patient/Guardian Signature: _____