YING PENG MD PhD
comprehensive neurology care

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Diplomate, American Board in Neurology and Special Qualification in Child Neurology
Diplomate, American Board in Clinical Neurophysiology

Patient Financial Responsibility

As a courtesy to our patients we have enrolled in numerous insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan In addition to any lapses in insurance coverage. Any charges that occur as a result of Insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

The patient (or patient's guardian) is ultimately responsible for the payment for her treatment and care.

Please initial below that you have read and understand the financial policy of our office.

_____ We are pleased to assist you by billing your contracted insurance. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.

_____ Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatments not covered by their insurance plan. Payment in full is due at the time of service. For your convenience, we accept cash, check, and most major credit cards at our office.

_____ I understand that my Insurance contract is between my insurance company and me. It is the responsibility of the patient to know and understand their medical Insurance benefits. If my insurance has not paid my claim within 60 days from the date insurance was billed, I will be responsible for payment. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being placed in a state of delinquency. If this becomes necessary, I agree to pay all collection fees, which include but are not limited to: collection fees and interest, court fees, attorney fees and any other fees for the collection of my account balance. If your account is sent to collections, there is a possibility that you may be discharged from the practice.
_____ I also understand that if I write a check that is returned for any reason, I will be charged a fee.

I hereby authorize the physician to release any and all Information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize insurance benefit payment be paid directly to physician for services rendered to the patient.

A copy of this agreement may be used in place of the original

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Patient Printed Name Responsible Party Printed Name