ADVANCED
NEUROSURGERY
ASSOCIATES

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Payment Policy

Dr. Fried, Dr. El Khashab and Dr. Rathmann are non-participating providers with most insurance companies. It is important for you to know the extent of coverage for any particular treatment may vary between health plan packages.

We will cooperate with your insurance plan to supply necessary information and obtain authorization when appropriate. However, it is important for you to know your financial obligations and understand that they may range from a small co-payment or co-insurance amount for an amount for an office visit or service, to the full charge of a procedure that is not covered by health insurance. Some information related to these obligations, most likely, is stated on your membership identification card or policy. However, you should contact your insurance company if you have questions related to a specific treatment, associated coverage, and your financial obligations. **Please note: We are not responsible for informing the patients if they require a referral and or an authorization.**

You are responsible for all applicable charges on the day you receive treatment. If you do not have insurance, or Dr. Fried, Dr. El Khashab and Dr. Rathmann do not participate in your plan, you are responsible for the full payment on the day of service for all charges incurred. If you treatment is covered by insurance and Dr. Fried, Dr. El Khashab and Dr. Rathmann participates (out-of-network) in your health plan, we will submit claims for services rendered on your behalf. However, you are responsible for all applicable co-payments, co-insurance, and payment balances not covered by your health plan. For your convenience, we accept payment in the form of **Cash, Check, Visa and Mastercard only.** Thank you for choosing the office of advanced Neurosurgery Associates, Pediatric and Adult Neurosurgery, for your health care needs.

By signing below, I hereby authorize and give consent to Advanced Neurosurgery Associates to speak to my insurance company on my behalf concerning any medical or claim inquiries including but not limited to claim appeals. Additionally, should I receive a payment from my insurance company for any services I will endorse the check to Advanced Neurosurgery Associates.

I have read and understand this payment policy and I accept responsibility for my financial obligations related to treatment rendered by Advanced Neurosurgery Associates.

Signature:_____Date_____
Please Print Name:_____