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**Payment Policy Agreement**

Michael P. Verdon DO, FACOS

Dayton Neurologic Associates requires payment of any portions of our services that are the patient’s responsibility at the time of service. If you are covered by an insurance plan that Dayton Neurologic Associates participates with, and the plan requires a co-payment, Dayton Neurologic Associates will collect the copay at the time of service.

* IT IS YOUR RESPONSIBILITY TO VERIFY YOUR INSURANCE COVERAGE!
* As a service to you, our patient, we will submit all the necessary insurance information to your insurance company for payment of your services. We must have your authorization to release medical information to your insurance carrier.
* Medicare assignment is accepted, and Dayton Neurologic Associates will bill directly for services. Patient will be required to make payment of deductible or co-insurance after Medicare has paid for the service.
* If you are being seen at Dayton Neurologic Associates for an injury/condition that may involve Worker’s Compensation benefits, Dayton Neurologic Associates will make reasonable efforts to obtain approval and payment from the Bureau of Workers’ Compensation (BWC); you are responsible for payment of your services. As stated earlier, we will bill your private insurance company (if applicable). You will be billed for any portion not paid by your insurance company.
* We expect a response from your insurance company within 30 days of our billing date. You are responsible to pay any portion of the charges not covered by your insurance company (ies). Dayton Neurologic Associates will bill you for these charges.
* WHEN YOU RECEIVE PAYMENT FROM YOUR INSURACE PROVIDER FOR SERVICES PROVIDED BY DAYTON NEUROLOGIC ASSOCIATES; IT IS YOUR RESPONSIBILITY TO REMIT THE ENTIRE AMOUNT TO DAYTON NEUROLOGIC ASSOCIATES WITHIN 10 (TEN) BUSINESS DAYS. PAYMENT ARRANGEMENTS WILL NOT BE ACCEPTED ON THE MONEY YOU RECEIVE FROM YOUR INSURANCE COMPANY.
* You will be charged $35 for any returned checks. You will be required to pay the $35 return check fee and the amount of the returned check in cash, prior to your next visit.
* Failure to pay your account balance will result in the account going to collections. Charges may be assessed on accounts going to collections.

By signing this agreement, I certify that the facts stated are correct. I hereby assign and authorize payment directly to Dayton Neurologic Associates of all health insurance benefits related to my care. I authorize Dayton Neurologic Associates to release my medical information to any insurer, compensation carrier, welfare agency, or its intermediaries or carriers who may be providing financial assistance.

I HAVE READ THE ABOVE AND AS THE PATIENT, HIS/HER PARENT/GUARDIAN OR DULY APPOINTED

REPRESENTATIVE, UNDERSTAND AND ACCEPT THESE TERMS.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_