Progressive Neurology & Sleep Center
Quality Care You Deserve

Office Policy

- Please complete registration form and medical history form before your new patient appointment.
- Please provide us with a valid medical insurance card and a photo ID, as well as new insurance cards as they become available.
- Please provide accurate contact information. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means.
- To ensure accurate processing of prescriptions, we ask that all refill requests are processed through your pharmacy. Your pharmacy can still request the refill even if you have no refills remaining. Routine refill requests may take up to 48 hours.
- It might take up to 2-3 working days to process forms, depending on the amount of details requested. Form fees of $25 will apply.
- We are happy to provide you with a copy of your medical record. There is a fee for copied medical records, which might depend on amount of medical record. We will notify you of the records fee and it should be paid prior to the release of the records. We require at least 5 business days to receive copies of medical records.
- Your appointment is very important to us. All appointments should be canceled or rescheduled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of up to $50.00. Please help us serve you better by keeping your scheduled appointments.
- You should arrive at least 10 minutes before your scheduled appointment to allow enough time for check in. However, if you arrive 5 minutes late for your appointment, we reserve the right to reschedule your appointment. If you are running late, please call our receptionist to check if you need to reschedule.

Financial Policy

- We accept assignment of insurance benefits as a courtesy to our patients. Any remaining balance will be the patient's responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be the patient's responsibility.
- Services may require a referral or authorization prior to being seen. Please be aware that some services provided may not be covered by Medicare or other insurances and may be considered not medically necessary, experimental or investigational. Payment for all uncovered services will be patient’s responsibility.
- Certain health insurance plans require that you obtain a referral from your Primary Care Physician before visiting a specialist’s office. It is the patient’s responsibility to acquire this referral. Alternative payment arrangements or rescheduling of your appointment may be necessary if proper authorization is not obtained.
- All copayments are to be paid at the time service is rendered. Please be aware that some visits performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly.

- If your account is sent to collections a 25% collections fee will be added. There is $25 fees for return check.
- You will be responsible to pay any collection costs and/or reasonable attorney fees, if a delinquent balance is placed with a collection agency and/or attorney for collection, or suit.

Financial Agreement, Assignment of benefits and Authorization to release records

I have read, understand and agree to this office and financial policy

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Progressive Neurology and Sleep Center PLLC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance.

I hereby authorize Progressive Neurology and Sleep Center PLLC to release any and all information necessary to payment. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information, including medical information, for this or any related claim to the above named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Name of Patient/Guarantor:_____

Signature of Patient/Guarantor: _____Date: _____