Office Policy

Health Insurance

Our office will do its best to assist you with your insurance reimbursement for Dr. Katz's services; however, it is your responsibility to be informed of your insurance benefits and requirements. Please understand that your health insurance policy is a contract between you and your insurance carrier, not between you and Bethesda Neurology, LLC. Therefore, you are responsible for any pre-authorizations and/or referrals required to see Dr. Katz. Most patients with health insurance also have deductibles and co-pays that are due at the time of service. Any fees not paid by your insurance company within 60 days after a visit are your responsibility. If you have no health insurance, you must pay in full at the time of the visit.

Missed or Cancelled Appointments

Your appointment is time reserved for you. Dr. Katz does not "double book" patients. Please be assured that we make every effort to honor your appointment time and ask that you extend the same courtesy to us. If unanticipated circumstances require you to cancel your appointment, please provide at least one business day's notice prior to the appointment, or you will be charged a $50.00 missed appointment fee.

Collection Fees

Please be advised that fees incurred to collect payment, including but not limited to the cost of mailing statements, reasonable attorney's fees and other costs of collection will be the patient's responsibility.

Service Charges

- 1.5% monthly interest rate will be applied to balances over 30 days.
- To defray the cost of collecting payment after the date of service, a monthly $5.00 billing fee will be added to monthly statements sent out.
- There will be a $25.00 fee for returned checks.
- If you require non-medical services (insurance forms, disability forms, etc.) which require significant staff and/or physician time, a minimum $25.00 fee will be charged.

Financial Consent and HIPAA Privacy Acknowledgement

I certify that I have read, understand, and agree to the terms of this policy. I also acknowledge receipt of Bethesda Neurology, LLC Notice of Privacy Practices.

Patient Name:_____

Responsible Party Signature:_____ Date:_____

Please list names of any persons authorized to discuss medical information (ex. health care providers, family members, caretakers, friends):_____

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