OUR POLICIES: EMG/NCV TESTING

1. You will be responsible to pay your co-payment, coinsurance (10%, 20%, etc.) and any applicable deductible at the time of service. If you have no insurance and are a "Prompt Pay" patient, you are required to have a minimum of $250.00 on the date of your test to be applied toward your account. We reserve the right to require payment in full at the time of service for any account. There is a $20.00 fee on all returned checks. We accept cash, checks, credit and debit cards.

2. Responsibility for the full charges of your testing services is yours. It will be necessary for you to make the proper arrangements to handle the uninsured portions of your charges. As a courtesy to you, we will file your primary insurance free of charge on our standard form, provided all necessary information is given. If your company requires special, additional forms to be filed, you will be charged a filing fee of $20.00. If you are unable to abide by the above policy, please make arrangements with our office staff.

3. We reserve the right to withhold the release of your medical records if your account is delinquent.

The statements contained herein are true and complete to the best of my knowledge. I understand fully the payment policy and billing procedures of HealthWorks. I hereby authorize HealthWorks to furnish my insurance company, attorney or legal representative all information which said parties may request concerning my present illness, injury or condition.

I hereby assign to HealthWorks, all money to which I am entitled for medical expenses relative to the service reported herein, but not to exceed my indebtedness to HealthWorks. It is understood that any money received from the above-named parties over and above my indebtedness, will be refunded (either to me or my insuror, whichever is the source of the over-payment) when my bill is paid in full. I understand I am financially responsible to HealthWorks for charges not covered by my insurance company. I certify by my signature that I have read and agree with this information. I also certify that I consent to evaluation and treatment by the staff of HealthWorks/Hornsby Rehabilitation Services, Inc.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

****Important Notice: Cell Phones are not allowed in HealthWorks Treatment Areas. Please turn off your cell phone or leave it in your car. Thank you for your cooperation.**

Patient's Signature _____ Date _____

Parent's/Responsible Party's Signature (if applicable)_____Date_____