



# FEIGENBAUM NEUROSURGERY

Specializing in the treatment of spinal meningeal cysts  
Frank Feigenbaum, M.D., FAANS, FACS

## **PATIENT PRACTICE AGREEMENT**

**Insurance Billing:** Insurance is a contract between you and your insurance company. It is your responsibility to know your plan coverage, benefits, eligibility, cost share amounts (deductible, co-payment, co-insurance, etc.) exclusions, limitations, referral, and pre-authorization requirements for specialty services. It is your responsibility to confirm that Feigenbaum Neurosurgery, PA (FN) participates in your plan. If FN participates with your insurance plan, we will file a claim on your behalf and bill you for your portion after insurance processing. FN requires a valid picture ID, all current insurance information, your referral, and an approved pre-authorization to bill your insurance for the visit. **All copays are due at the time of service.** For surgery services, FN will verify your insurance eligibility, benefits, and assist in obtaining prior authorization for surgery and in-patient hospitalization services but **this is not a guarantee of payment.** We can estimate what your insurance company may pay but the final determination of benefits is made by your insurance.

- **Payment Responsibility for Non-Covered Services:** Limited coverage is common among insurance plans. If non-covered services are known prior to surgery, payment is due before services are rendered.

- **Self-pay Accounts:** Self-pay accounts include patients with no insurance, or patients with no approved pre-authorization by their insurance. Payment is required prior to the date of service. To determine payment amounts for an office appointment or surgery, please call 214-351-8450.

- **Returned Checks:** The charge for a returned check is \$25.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount.

- **Outstanding Balance Policy:** Billing Statements sent will reflect the amount you owe after insurance processing. Payment in full is expected on receipt of your statement. If no resolution can be made within thirty (30) calendar days, your account may be sent to a collection agency, and you may be discharged from FN. If you have questions regarding any bills, balances or statements regarding services rendered by our group please contact our Billing department at 816-615-2711 or 502-825-1397.

- **Surgery Claims:** Please allow 30-45 days for claim processing following surgery. It is common to get a letter from your insurance requesting information from FN or denying payment. FN billing department will provide the necessary documentation requested by your insurance. Please contact our billing department for all questions regarding any insurance correspondence you receive in the mail. If necessary, you may be asked to help in the appeal process.

- **Other Billing:** Questions you have regarding bills from the hospital or other providers will need to be addressed to the name/company listed on the invoice. You may receive statements from the hospital, neuromonitoring company (Neurophysiology Associates, Biotronic, or NuVasive), anesthesia, Radiology, pain management, internal medicine group, and physical therapy, if applicable.

- **Medicare:** FN accepts Medicare assignment on covered Medicare charges. There is a possibility that some services are not covered by Medicare. When services fall under that category, you will be asked to sign an advanced beneficiary notice (ABN) indicating that you acknowledge non-coverage and that you agree to pay in full prior to services being rendered. Medicare 20% coinsurance will be billed after we receive payment from Medicare. Payment of the annual deductible and any non-covered charges is expected at the time of service unless you have secondary insurance accepted by the group.

- **Worker's Compensation, Motor Vehicle Accidents (MVA), Third-Party Liability Insurance:** Feigenbaum Neurosurgery does not accept Worker's Compensation, MVA, or any Third-Party Liability Insurance (auto, homeowner, etc.). You are responsible for payment of services rendered. It is the patient's responsibility to seek reimbursement from the third-party insurance.

***If you have any questions or need clarification of any of the above policies, please contact our office at 214-351-8450.***

**By signing this, I acknowledge I have read the above information and understand and agree to all the terms listed.**

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
DOB