NOVA NeuroIntegrative Medicine, PLC

Practice Policies

Thank you for choosing us as your Integrative Medicine provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment and practice policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Payment in full is expected at each visit.

An introductory, get-acquainted visit (if desired) may be arranged. It lasts a total of 30 minutes and is free of charge.

A comprehensive intake visit lasts around 2-3 hours.

If any sort of therapy, such as neurotherapy is performed, sessions (around 40 minutes each) are expected to occur at least twice a week. Most patients require 40-60 and sometimes more sessions to achieve and maintain significant improvement from neurotherapy. Approximately 80% of clients achieve significant improvements from symptoms identified at the initial visit from neurotherapy.

All visits to the office are billed at a rate of approximately $240/hour. Complex visits may be slightly more expensive.

For most patients, TOVA testing is required at the beginning of any therapy and after each 20 sessions.

2. Insurance. We participate in no insurance plans, but we will provide bills and medical documentation that you may submit to your insurance company for reimbursement. There may be charges for providing documentation (see 6). Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage for our services.

3. Medicare non-covered services. Please be aware that Medicare does not cover the services that we provide. You must pay for these services in full at the time of visit.

4. Nonpayment. If your account is over 10 days past due, you will receive a letter stating that you have 5 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. Our physician will only be able to treat you on an emergency basis if your account is over 15 days past due and arrangements have not been made to pay money owed.

5. Missed appointments. Our policy is to charge for missed appointments canceled with less than ***1 working day's*** (***24 hours***) notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

6. Written reports to agencies, professionals and insurance companies, as well as review of documents such as test reports or hospital records will be billed at a rate of $40.00/10 minutes.

7. Telephone calls of 10 minutes or longer will be billed at a rate of $40.00/10 minutes.

8. Emergencies. Our physician does not carry a pager and is not available for emergencies. Emergency problems should be referred to your regular physicians or the emergency room. Urgent matters will be dealt with during normal business hours.

9. Medical liability. NOVA NeuroIntegrative Medicine, PLC currently does not have a medical liability insurance policy in effect. We are working to obtain coverage at reasonable rates.

10. Controlled substances and medications. No prescriptions for controlled substances will be provided by our physician. NOVA NeuroIntegrative Medicine is a consultant practice and therefore leaves the specifics of medication therapy to your regular prescribing physicians/providers. We will, however, be able to recommend possible changes in medication, which are then your responsibility to discuss with your normal prescribing physician/provider.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our policies. Please let us know if you have any questions or concerns.

I have read and understand the payment and practice policies and agree to abide by their guidelines:

_____ _____

Signature of patient or responsible party **Date**

_____

Printed Name