NEUROLOGY ASSOCIATES OF SANTA BARBARA **TEL: 805.682.8153**
PHILIP R. DELIO MD **FAX: 805.682.5585**
MICHAEL G. GIBBS MD

PATIENT:_____

WE ARE NOT CONTRACTED WITH MOST INSURANCE COMPANIES.
WE ARE NOT CONTRACTED WITH ANTHEM BLUE CROSS OR BLUE SHIELD

The following is a list of those we are contracted with:

MEDICARE
TRICARE
S.B. COTTAGE HOSPITAL EMPLOYEE HEALTH
S.B. SELECT IPA
CENCAL HEALTH

INSURANCE CLAIM FILING
We will bill your primary insurance company for you. For those companies that we are not contracted with we will expect payment in full on the date of service – for most visits, excluding tests and injections. Your insurance company will then reimburse you directly.

MEDICARE AS SECONDARY PAYOR
When Medicare is the secondary payor it is your responsibility to see that this office receives a copy of the primary insurance company's Explanation of Benefits (EOB). We are required to send this along with the Medicare claim.

FINANCIAL POLICY
Special needs are understood by this office. It may be necessary to set up a payment plan for a patient. If this situation is necessary for you, please bring the matter up as soon as possible. Any credit granted shall be paid promptly in accordance with terms and agreements. Should you default on payment of your account, the account will be sent to a collection agency and you will be charged $25 to cover late payment fees.

ASSIGNMENT OF BENEFITS
I, the undersigned, have insurance coverage with_____(**Name of Ins Co.)** and assign directly to Neurology Associates of Santa Barbara all medical benefits if any, otherwise payable to me for services rendered by those insurance companies that they are contracted with. If my insurance coverage is not through one of the contracted companies listed above I understand that the insurance company will remit payment, if any, directly to me. I understand that I am financially responsible for all charges for medical services provided by Neurology Associates of Santa Barbara whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits to my insurance company.

SIGNED_____**DATE**_____