MODY & MILLER, M.D., P.A.
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3001 S. HANOVER STREET, GNM1
BALTIMORE, MD 21225
PHONE: (410)350-3261

Dear Patient:

Your Primary Care Physician has chosen Dr.'s Mody & Miller for your neurology needs. Please take a moment to review our financial policy.

REFERRALS:

If you are enrolled in an HMO which requires a referral from your Primary Care Physician, you must have the referral with you at the time of service in order to be seen by either Dr. Mody or Dr. Miller. If you arrive without your referral your appointment with be rescheduled. There will be **NO EXCEPTIONS** to this policy.

CO-PAYMENTS:

If you are an enrollee of a managed care plan (HMO or PPO) that we are contracted with you are required to pay the co-payment each time that you are seen by either Dr. Mody or Dr. Miller. If you are not prepared to pay the co-payment, there will be a $10 billing fee in addition to your co-payment or you have the option of rescheduling your appointment.

BILLING:

In the event that there is a balance due from you after your insurance carrier has paid its portion, we will bill you. We send three bills (statements of account). The last statement will advise you that no further statements will be sent to you and that your account will be turned over to a national collection service. To avoid this, please pay your bill promptly. If the balance is a rather large one and you can not afford to pay the balance all at once, please do not hesitate to contact our office and we will be glad to set up a budget billing plan for you. If you do not understand the reason you owe a balance, please do not hesitate to contact our office. A staff member will explain the balance to you and answer any questions you may have.

MISSED APPOINTMENTS/LATE CANCELATIONS:

If you miss your appointment or cancel the day of (with the exception of emergencies)…YOU, not your insurance company…will be charged a $25.00 fee. It is a courtesy that we call to remind you of your appointment, which we do 1-2 days prior.

I HAVE READ THE ABOVE AND UNDERSTAND MY OBLIGATIONS.

_____ _____

SIGNATURE DATE

_____

PRINTED PATIENT'S NAME