NEUROSCIENCE
CONSULTANTS, PLC
1830 Town Center Dr, Suite 410 | Reston, VA 20190
Office: 703.478.0440 | Fax: 703.742.9210 | www.nscplc.com
Jon D. Peters, MD

PAYMENT POLICY

PAYMENTS: Payment is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment, or non-covered charges from your insurance company. If you do not have insurance coverage, payment in full is expected at the time of your visit per our Self-Pay Agreement. Any account balance must be resolved prior to any additional services being performed.

COLLECTION FEES: Patients have 90 days to pay any unpaid balance and if not paid in full, the account will be sent to collections. In the event that the account if placed in collection status, the patient will be obligated to pay the list price (minus any payments made) in addition to a 25% collection fee. If payment is not made to the collection agency and suit is filed, I will be responsible for any court and attorney fees, in addition to the 25% collection fee. In the event of a return check, a $35.00 charge will be assessed.

NO SHOW FEES: If Neuroscience Consultants, PLC is not given advanced notice of 48 business hours for an appointment cancellation, a no-show fee of $150.00 for physician visits and $250.00 for diagnostic testing will be charged to the patient's account. This fee is subject to the same collection policy noted above.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE RECEIVED THIS INFORMATION, READ AND UNDERSTAND ITS CONTENTS. MY SIGNATURE ON THIS DOCUMENT IS VALID FOR 1 CALENDAR YEAR AND COVERS ALL SERVICES RENDERED WITHIN THAT YEAR. ANY MODIFICATIONS/ALTERATIONS TO THIS DOCUMENT ARE NULL AND VOID.

PATIENT NAME: _____

SIGNATURE OF PATIENT/REPRESENTATIVE: _____ DATE: _____