<u>FINANCIAL TERMS</u>

1. You agree to fully cooperate with us in collecting the insurance payment(s) and provide us with a copy of the summary of benefits and coverage for your plan ("summary plan description") if requested. You will be personally responsible for any amounts due to Neurological Surgery, P.C. ("NSPC") that are not covered by your insurance, including amounts that become due as a result of incorrect insurance information. The estimated amount that you will be billed is available upon request.

2. Depending on your health insurance policy, you will be responsible for CO-PAYS and DEDUCTIBLES for office visits or for surgical procedures at NSPC.

3. If the doctor you plan to see is not in your network, and your insurance policy does not allow for out-of-network benefits, <u>ARRANGEMENTS CAN OFTEN BE MADE FOR YOU TO SEE ONE OF OUR DOCTORS IN YOUR PLAN</u>.

4. If the doctor scheduled to perform your surgery is not in your network but your insurance policy allows out-of- network benefits, we will consider the amount paid by your insurance policy and the requirements of applicable law in determining the amount of your out-of-pocket expenses. We will provide you with an estimate of such expenses upon request.

5. If you are scheduled for surgery, any of our personnel who are providing necessary services for your procedure in the operating room or participating in your care (for example, physician assistant, co-surgeon, and/or monitoring team) may be permitted to submit separate bills under the same conditions as above.

6. Once your insurance has received and processed your claim, they should send you a statement ("Explanation of Benefits") within 30-45 days. If you have any questions regarding your insurance coverage, we may be able to assist you.

7. Questions regarding management of any balance can be discussed with the billing department at 516-442-3461.

8. It is not our intent to impose financial hardship. If any of these terms creates a hardship, the Billing Department has flexible terms and will cooperate with you to provide a fair and reasonable financial settlement or your obligations to NSPC.

By signing below you acknowledge that you agree to and accept these terms.

Name: ____________________________ Signature: ____________________________________

Keep one copy and return signed copy to NSPC Date: ____________________________