Consultants in Neurology. P.A.
Rowe Neurology Institute
8550 Marshall Drive, Suite 100
Lenexa, KS 66214
913.894.1500 or 800.753.6992

Dear Patient:

RE: **Credit Policy**

We want to make you aware of our credit policy.

All co-pays must be paid at the time of your appointment. This is a requirement of your insurance company.

After your insurance has paid its portion, the balance is due when you receive your statement unless previous arrangements have been made and approved.

Options for large amounts:

1) For large deductibles and co-portions (insurance), (over $500) a credit card will be held on file. Arrangements of 6 monthly payments must be made with our billing department prior to scheduling- via a credit card held on file. No charges against your credit card will commence until insurance pays or determines their portion. Please call our office upon receipt of your first statement to initiate the first payment either with credit card on file or other means of payment.

2) Care Credit. You may apply for longer payment arrangements of 12 to 18 months of payments with no interest! This depends on your credit worthiness. Care Credit is a confidential credit card company (focused on healthcare) that you can apply for in the comfort of your home either by phone or directly online.

Please call our billing office at 913-894-1500 ext 159 to make arrangements or to receive more information about Care Credit.

All arrangements need to be set up prior to testing or treatment. We will do whatever we can to assist you in payment for your services.

Cindy S
Patient Accounts Manager
913-894-1500 ext 159

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Authorization to Debit Credit Card

Credit Card type

- ☐ Visa
- ☐ MasterCard
- ☐ Discover
- ☐ American Express

Name as it appears on the card: _____

Credit Card #: _____ CVV # _____

Expiration date: _____

☐ I authorize Consultants in Neurology / Rowe Neurology Institute to use my credit card on file for monthly installments for up to six (6) months on the patient account balance listed herein, after insurance payments, which may include my deductible and co-pays. I understand that upon receipt of my first statement from Consultants in Neurology, I am to call the billing office to initiate these payments to avoid an auto charge and that failure to do so may result in the entire balance being charged to the card for which I have provided information.

Guarantor: _____ Date: _____
Signature

For Office Use Only

☐ Credit Card
☐ Debit Card

Patient Account: _____ Patient Name: _____

Verified by: _____ Date verified: _____