Northwest Arkansas EMG Clinic
Miles M. Johnson, M.D.

Financial Policy

This notice explains any financial information regarding payment of services performed by NWA EMG Clinic involving you, and any responsibilities our services will extend to any insurance company.

Insurance Coverage

If you have insurance coverage, you will be contacted by our billing office prior to the scheduled appointment date, if there is a deductible that must be met. You will be informed of an estimate of what will be your responsibility. You are expected to bring the full amount discussed. We will file a claim to the insurance company and any portion that the insurance does not cover will be your responsibility.

Workers compensation

If you have workers compensation we will be happy to file the claim for you. We must have all information necessary to file. If for some reason your work comp is denied, then the balance becomes your responsibility. If you wish us to file it to your commercial insurance, we must be informed by you with all the necessary information, otherwise the balance again becomes your responsibility.

Personal Injury or MVA

We will be happy to file any of these claims for you, if we have all the information necessary. If it is a third party claim you may be asked to help us in the process of retaining information. If we do not get all the information needed then the balance will be your responsibility until we get the necessary information. Also, we will send you a monthly statement to remind you of your balance with us. If a settlement is reached and the payment is sent to you, then you will be responsible to pay us the balance on your account.

Medicaid

If for some reason Medicaid denies payment on any portion of our services,
then we will file an extension of benefits as a courtesy to you. Then, if the extension is denied, the remaining balance is your responsibility.

Allowable forms of payment:	Cash, check, money order, or credit card.
Insufficient funds charge:	There will be a $25.00 charge for any insufficient funds check.

We appreciate you taking the time to read this information and will be happy to discuss any aspect of our financial policy. If you have any questions please let us know.

Patient Signature:_____Date_____

I hereby acknowledge that I have been presented with a copy of "Northwest Arkansas EMG Clinic Notice of Privacy" policy.

Patient Signature_____Date_____