Neurology and
Neurosurgery Associates, P.A.
Providing complete neurological and spinal care

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Neurological Surgery
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Neurology
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Adult and Pediatric Neurology
T. Richard Hostler, M.D.

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Central Florida MRI
180 Ave. A., S.E.
Winter Haven, FL 33880
(863-293-1101

Haines City Office
175 Patterson Road
Haines City, Fl 33884

Lakeland Office
University Parkway Center
4712 Exploration Avenue
Lakeland, FL 33812

NAME:_____DOB:_____DATE:_____

NNA OFFICE POLICIES

NO SHOW/CANCELLATION POLICY

If it is necessary to cancel or reschedule your appointment, please do so at least 24 hours prior to your appointment. If we do not receive the cancellation notice, there is a $25 fee for missed appointments and a $50 fee for missed testing. This charge will be payable by the patient and will not be billed to any insurance company. the fee must be paid by the patient prior to rescheduling the appointment.

FORM COMPLETION POLICY

Neurology & Neurosurgery Associates charges for form completion. this charge is $10 per form and will be payable by the patient and will not be billed to any insurance company. This fee must be paid prior to the form being completed. Requests will be completed within 7 to 10 business days.

MESSAGES

Messages left on voicemail will be answered in the order in which they were received (unless urgent). All messages will be answered within 48 hours of receipt. We ask that you not leave multiple messages within that time frame, as it will only slow down the process. Our staff strives to answer all their messages as quickly as possible and voicemail is checked often throughout each business day.

MEDICATION REFILLS

Please allow 2 to 3 business days for medication refills. Refill requests received after business hours, or on weekends and holidays, will be addressed on the next business day. Any requests for refills received after 3 p.m. will be addressed on the next business day. Please contact your pharmacy and ask that they fax your refill request to our office. **DO NOT WAIT until you are out of your medication before you request refills. Your doctor may not be available to approve your refill on an urgent basis.**

MEDICAL RECORDS RELEASE POLICY

You will need to sign a release form requesting that our office release your medical records to any other doctor or facility. If any attorney or insurance company is requesting your records they must submit a written request with a signed release. Please allow up to 10 business days for the request to be processed. Please note that we can only release the information that was completed by our providers. We cannot release the information from other physicians, hospitals, etc.

FINANCIAL POLICY

As a courtesy we will file all claims directly to your insurance company on your behalf. Please note that you are responsible for providing your complete and correct insurance information at the time of service. Please inform our office of any insurance or billing changes immediately. If we are not provided with the correct information at the time of service, the patient will be held responsible for the bill. The patient is responsible for knowing their own insurance policy benefits and coverage limitations and informing our office of any non-covered services. If your insurance requires a referral and/or authorization, please obtain those prior to your service. All copays are due at the time of service. Self-pay accounts must be paid in full at the time of service.

Is this auto related (Y / N) Is this work related (Y / N)

By signing, I acknowledge that I have read and agree to the policies set forth above.

SIGNATURE:_____DATE:_____
Signature of patient or authorized representative

RELATIONSHIP TO PATIENT:_____