NEUROSCIENCE AND REHAB ASSOCIATES
NANDA N. KUMAR, M.D.
Manhattan Medical Center
1133 College Avenue BLDG B, STE 224
Manhattan, KS 66502
Telephone (785) 537-9349 Fax (785) 537-9486

Office Financial Policy

1. PAYMENT in full 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 amount, or non-covered charges from your insurance company.

2. OUTSTANDING BALANCES will be transferred to a collections agency after they are 121 days past due. We understand that people have financial difficulty, so please communicate with our billing and collection staff so they can assist you and prevent further collection actions. If your account is in collections, please contact KCI at 800-333-8335.

3. INSURANCE is filed by our office on your behalf. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.

4. RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, money order, or pay by credit card to cover the amount of the check plus the $30.00 service charge to pay the balance prior to receiving services from our staff or the physician.

5. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $30 missed appointment fee. This fee is not covered by insurance and will be due before you are seen in our office again. We have an answering service that allows messages to be left 24 hours a day, 7 days a week.

6. SELF-PAY patients are given a discount when fees are paid at time of service. If you are unable to pay the entire amount due, a payment plan must be set up.

I HAVE READ AND UNDERSTAND THE PRACTICE'S FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

____________________________________ __________________________
Signature of Patient (or Guarantor, if applicable) Date

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Please print the name of the patient