

The Metropolitan Neurosurgery Group LLC
1010 Wayne Avenue, Ste. 420, Silver Spring, MD 20910
Phone: 301-557-9051 Fax: 301-654-9394

FINANCIAL NOTICE

I, _____ acknowledge that, if I have an appointment scheduled with Metropolitan Neurosurgery Group, LLC and do not cancel within the given time my credit card will be charged respectively.

I acknowledge that if my account is turned over to collections there is a **\$50.00 collection fee**. The office will work on a payment plan if necessary according to the following structure:

\$50 balance or less: Entire balance is **due the first month**

\$51 - \$500 balance: **\$50 minimum** monthly payment

\$501-\$1000 balance: **\$100 minimum** monthly payment

\$1001-\$2500 balance: **\$200 minimum** monthly payment

Over \$2500 balance: minimum monthly payment will need to be approved by management.

I acknowledge that there will be a **fee of \$25.00 for all medical forms and letters** to be completed by our office. Payment will be due once these are ready. These will be done within 10 working days. If I need them expedite, an additional \$15.00 will be charged.

Please be advised **all returned checks and declined credit card transactions will be subject to \$35.00 processing fee**.

I, the undersigned, do hereby understand and accept these policies of Metropolitan Neurosurgery Group, LLC

Signature of patient: _____ Date: _____