BAROLAT NEUROSCIENCE
Giancarlo Barolat, MD
Paul Battle, PA-C

1721 E. 19TH Ave. Ste., 434
Professional Plaza East
Denver, CO 218
(303) 865-7800 (866) 372-5075
FAX (303) 865-7804

FINANCIAL POLICY

We value our relationship with you and want to assure its ongoing success through a mutual understanding of our financial policies. Please familiarize yourself with the information below and speak with a staff member if you have any questions.

1. The **ESTIMATED** cost of Dr. Barolat's fee for surgery is **$_____.**

2. The total payment of the estimated surgeon fee or a deposit towards the estimated surgeon fee is due 14 days prior to surgery. If payment is not received 14 days prior, surgery may be cancelled. This amount is **$_____.**

3. In the event that surgical assistant services are utilized, there may be additional charges.

4. Surgery cancellations and changes create serious scheduling problems and will be made only if you are experiencing health problems or in case of an emergency. The surgical facility, anesthesiologist, surgeon and other staff are reserved and prescheduled in advance.

5. In the event surgery is cancelled and rescheduled, all prepaid fees will be applied to the new surgery date. **Fifty percent** of the TOTAL ESTIMATED COST of surgeon fees is **NON-REFUNDABLE** if surgery is cancelled less than fourteen days before your surgery date and if surgery is not rescheduled within six months.

6. Should complications develop as a result of your surgery, you may incur additional costs. If surgical revisions are necessary, you are responsible for the surgeon and other associated fees.

7. The surgeon fee includes three months of normal post-operative care. You will be charged a fee for each office visit after three months (90 days) of post-operative care as related to existing procedure/condition.

I certify that I have read and fully understand Barolat Neuroscience financial policies. I agree to be personally responsible for all payments.

Patient Name: _____ Date: _____

Patient/ Responsible Party's Signature: _____Date: _____

Patient Coordinator: _____Date: _____