NEUROLOGIC ASSOCIATES
SPINE, NERVE & BRAIN CENTER
The trusted authorities for exceptional care

NEUROLOGIC ASSOCIATES OF WAUKESHA – NEW PATIENT- INSTRUCTIONS
PLEASE KEEP THIS INSTRUCTION SLIP FOR FUTURE REFERENCE

We believe your appointment time is your time with the doctor, please arrive **20 to 30 minutes before your scheduled appointment time** to allow time for you to check in and have the coordinator get you into the room for your visit.

MyChart:

All Neurologic Associate patients are encouraged to communicate with us by signing up for MyChart by going to ProHealthCare.org

- It is easy to register and It is free to sign up
- You can view your medical information online 24/7
- You can receive many of your test results
- You can review your doctor's instructions
- You will receive important health information and reminders
- You can stay in touch with your doctor and our office
- You can manage your appointments
- And you can manage family members' medical information

Test Results:

Your doctor may require you to make a follow-up appointment to discuss your test results and plan for treatment. We will call you if something requires immediate action or the doctor has any additional instructions for you based on the test results that cannot wait until your follow up appointment. We may also call you if your doctor requests that we notify you that your test is normal. The results of your test may not be available for up to 2 weeks or longer depending on the test. **If you are not contacted, your test results will be discussed with you at your next appointment.**

Questions?: Please call your doctor's coordinator directly. If the coordinator is with patients, your call will go to the coordinator's voice mail for you to leave a message and the coordinator will call you within a few hours. Please call 262-542-9503 if you are calling to schedule an appointment.

At Your Next Appointment:

Please bring an updated detailed list of your medications to your visit. The accuracy of our information is based on the information you provide to us.

Important Tips for Prescription Refills:

Call your pharmacy

- If you have authorized refills your pharmacist can refill your prescription immediately.
- If not, then your pharmacist will contact us directly by phone or fax. Once you have requested the refill through your pharmacy you will need to call them to see when the prescription is ready; do not call our office. *This is a much safer and quicker method because your pharmacist knows the information we need to fill your prescription and speed up the process.*

Do not let your prescription run out

- Make sure you keep your scheduled appointment in order to keep your refill request current. You will need to be seen at least once annually to continue to receive prescription renewals.
- Plan ahead - request your refill from your pharmacy **at least** 72 hours (3 days) before you will run out of medication. Contact the pharmacy directly to see if your prescription is ready.
- If you request controlled substances on a Friday, evenings or weekends your request will not be filled. Controlled substance refill requests are processed Monday – Thursday during regular office hours.
- If you are overdue for a clinic visit and request a refill you may only get a 7-day supply. This may cause you to have an additional co-pay so it is important to see your physician consistently. Controlled substance prescriptions will not be refilled early. Written prescriptions cannot be picked up after 4:30pm daily and 3:30 on Fridays.

THIS AGREEMENT IS SIGNED AND MAINTAINED AS PART OF THE MEDICAL RECORD FOR ANY PATIENT RECEIVING A PRESCRIPTION FROM A NEUROLOGIC ASSOCIATES OF WAUKESHA PHYSICIAN.

THIS COPY IS FOR PATIENT INFORMATION ONLY TO KEEP FOR YOUR OWN FILES.

THIS IS A COPY OF THE AGREEMENT THAT YOU SIGNED AS A NEW PATIENT

MEDICATION THERAPY AGREEMENT

We, at Neurologic Associates of Waukesha (NAW), are committed to doing all we can to treat your medical condition and pain related to your medical condition. In some cases, narcotics are used as a therapeutic option in the management of post-surgical or chronic pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper medication and controlled substance use.

1. All medications and controlled substances must come from the one physician who has prescribed the medication or, during his absence, by the covering physician. If you are receiving controlled substance prescriptions from another physician you cannot receive them from a physician here at NAW. I will inform my NAW physician of all other controlled substances that have been prescribed for me. I understand that receiving controlled substance prescriptions from two physicians will most likely result in discharge from both practices. *You will need to see the prescribing NAW physician at least once annually to continue to receive prescription renewals. Patients receiving prescriptions for controlled substance may be required to see the physician every 3 months, or more frequently if ordered by their physician, for a face to face visit, to continue receiving prescriptions from their physician.* It is understood that failure to adhere to these policies will result in cessation of therapy with controlled substance prescribing by this physician and all physicians at Neurologic Associates of Waukesha.
2. It is best that all medications you receive come from one pharmacy and ALL controlled substances must be obtained at the same pharmacy for each refill. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:
   Pharmacy: _____
   Phone:_____ **Address:**_____
3. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care, for the purpose of maintaining accountability.
4. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to these medications.
5. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances or lack of the prescribed substance will result in your discharge from this practice.
6. I will not consume excessive amounts of alcohol in conjunction with narcotics, or will I use, purchase, or otherwise obtain any other legal or illegal drugs including marijuana or cocaine.
7. Medications will not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told is not enough.
8. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
9. **Early refills will not be given**. Renewals are based upon keeping scheduled appointments. Refills requests for my prescriptions must be made only at the time of an office visit or during regular office hours Monday through Thursday. Refills require at least 48 hours to complete the refill request. **No refills will be available during evenings or on weekends under any circumstances**. You will need to plan ahead in order to avoid running out of medication.
10. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.
11. You will be asked to sign for your prescription at pick up at our office. You will be required to show a photo ID to pick up your prescription. Prescriptions will only be released to you unless otherwise indicated. I give my permission to have (full legal name) _____DOB_____ pick up my prescription. I understand that this person will be required to show a photo ID and sign for the prescription at pick up. Prescriptions cannot be picked up after 4:30 pm daily or 3:30pm on Fridays.

I agree that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms

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Welcome And Thank You For Choosing
Neurologic Associates Of Waukesha

In order to streamline the registration process at your first visit we have enclosed the forms that will need to be completed before your visit. This will allow you to complete them in the comfort of your own home and have all of the insurance and other information at your fingertips, while completing the required forms. Please bring all of the **completed forms** with you and present them, along with your **insurance card** and **photo ID** to the receptionist when you check in. Please do not mail these forms back to our office, since they may not arrive before your visit and we would need you to complete the enclosed documents again in our waiting room before checking in. Unfortunately, the doctor will not be able to see you without having these forms completed. If you are unable to complete them before coming to your appointment you will need to **arrive 30 minutes before your appointment** time to complete the forms or we may need to reschedule your appointment.

We are required to collect all insurance co-pays at check in for each visit. We accept cash, check, MasterCard or Visa. Please have your co-pay ready when you check in.

We reserve the right to charge a $45.00 fee for appointments that are broken or not cancelled within 24 hours prior to the appointment time.

We will ask you for your insurance card and photo ID when you check in at each visit, to ensure we have the most current information on file. It is always best for you to check with your insurance company, by calling the number on the back of your insurance card, to ensure that we are an "in-network" provider in your plan and for you to receive the maximum payment benefits from your insurance company.

Please call us if you have any questions prior to your appointment at 262-542-9503.

We look forward to meeting you in person and assisting you with your healthcare needs.

NEUROLOGIC ASSOCIATES OF WAUKESHA HEALTH HISTORY

Completion of this form is required prior to first appointment

Patient Name: _____ Birth date: _____ Today's Date: _____

Occupation:_____

Chief Complaint: _____

History of present illness:

LOCATION: _____
(Where is the pain/problem?)

QUALITY: _____
(Example: ache, stab, burn)

SEVERITY: _____
(How severe is the pain on a scale from 0-10, 10 being most severe?)

DURATION: _____
(How long have you had this pain/problem? or, When did it start?)

TIMING: _____
(Does the pain/problem occur at a specific time?)

CONTEXT: _____
(What event started the pain/problem or gradual onset?)

ASSOCIATED SIGNS/SYMPTOMS: _____
(What other associated problems are you having?)

MODIFYING FACTORS: _____
(What makes the pain/problem worse or better? Or, have you had previous episodes?)

Past Medical History:

Have you ever had the following? (Please circle)

Measles……	Yes	No	Blood clotting disorder:	Yes	No	Bladder Infection……	Yes	No
Mumps……	Yes	No	Type: _____			Venereal Disease ……	Yes	No
Chickenpox……..	Yes	No	Blood or Plasma Transfusions…	Yes	No	Kidney Failure……	Yes	No
Whooping cough…….	Yes	No	Anemia……	Yes	No	Kidney Stones……	Yes	No
Polio……	Yes	No	Hemorrhoids…….....	Yes	No	AIDS or HIV+…….....	Yes	No
Scarlet Fever……	Yes	No	Glaucoma……	Yes	No	Hives or Eczema……	Yes	No
Diphtheria……	Yes	No	Cataracts.....	Yes	No	Bronchitis……	Yes	No
Smallpox……..	Yes	No	Diabetes……..	Yes	No	Asthma……	Yes	No
Rheumatic Fever……..	Yes	No	Cancer (Type:_____)	Yes	No	Tuberculosis……	Yes	No
Heart Attack…….....	Yes	No	Hernia……	Yes	No	Infectious Mono……..	Yes	No
Irregular Heartbeat…	Yes	No	Ulcer……..	Yes	No	Pneumonia……..	Yes	No
Vascular Disease…….	Yes	No	Hepatitis……	Yes	No	Back Trouble……...	Yes	No
CoronaryHeart Disease	Yes	No	Epilepsy……	Yes	No	Osteoporosis.....	Yes	No
Mitral Valve Prolapse..	Yes	No	Stroke…….. ……	Yes	No	Thyroid Disease.....	Yes	No
High Blood Pressure…	Yes	No	Migraine Headaches……..	Yes	No	Other diseases:		
Low Blood Pressure…	Yes	No	Arthritis….....	Yes	No			

Previous Hospitalizations/Surgeries/ Serious Illnesses: When? Hospital, City, State Doctor?

_____

_____

_____

_____

_____

_____

Patient Social History:

Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed
Number of Children: _____

Use of alcohol: ❒ Never ❒ Rarely ❒ Moderate ❒ Daily ❒ Drinks per week _____
Use of tobacco: ❒ Never ❒ Previously, but Quit_____ ❒ Current packs/day: _____
Use of drugs: ❒ Never ❒ Type/Frequency: _____
Caffeine: ❒ Never ❒ Rarely ❒ Moderate ❒ Daily
Exercise: ❒ Never ❒ Rarely ❒ Moderate ❒ Daily ❒ Activity Type:_____
Handed: ❒ Left ❒ Right ❒ Ambidextrous

Nutrition: ❒ Heart Healthy ❒ Low Sodium ❒ Carb Controlled ❒ Low Cholesterol ❒ Regular

Excessive exposure at home or work: ❒ Fumes ❒ Dust ❒ Solvents ❒ Air-borne particles ❒ Noise

NEUROLOGIC ASSOCIATES OF WAUKESHA
MEDICATION /ALLERGY FORM

Date:_____

Name:_____ **DOB**_____
(PLEASE PRINT)

ALLERGIES: PLEASE LIST ALL	**REACCTIONS:** **(PLEASE LIST ALLERGIC REACTION TO MEDICINE)**

Please provide us with a list of your current medications. Also, include any over the counter medication, vitamins and/or supplements.

Medication	**Dosage**	**Directions**	**Prescribing Doctor**
Example: Metoprolol	50 Mg.	1 daily	Dr. W. Williams

Patient Name: _____ **DOB:** _____

Family Medical History: (Circle what applies and indicate which family member and if Alive or Deceased):

			Family Member:				Family Member:
Hypertension……	Yes	No	_____	COPD…….....	Yes	No	_____
Coronary Heart Disease……	Yes	No	_____	Thyroid Disease……..	Yes	No	_____
Stroke……...	Yes	No	_____	Alcoholism…….	Yes	No	_____
Migraines…….	Yes	No	_____	Depression…….	Yes	No	_____
Parkinson's Disease……..	Yes	No	_____	Other Mental Illness…	Yes	No	_____
Hyperlipidemia:……...	Yes	No	_____	Multiple Sclerosis……	Yes	No	_____
Cancer (Type:)	Yes	No	_____	Other……...	Yes	No	_____
Diabetes (Type:)	Yes	No	_____				

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

Good general health lately……..	Yes
Recent weight Gain…….	Yes
Recent weight loss……...	Yes
Fatigue…….	Yes
Fever…….	Yes

Eyes

Blurred or double vision……..	Yes
Wear glasses/contact lenses…….	Yes
Eye disease (Type:)	Yes

Ears/ Nose/ Mouth/ Throat

Swollen glands in neck……	Yes
Hearing loss……. ……...	Yes
Ringing in ears…….	Yes
Earaches or drainage……	Yes
Chronic sinus problem or rhinitis	Yes
Nose bleeds……..	Yes
Mouth sores…….	Yes
Bleeding gums…….	Yes
Sore throat or voice change…….	Yes
Difficulty swallowing……..	Yes

Cardiovascular

Swelling of feet, ankles or hands.	Yes
Chest pain or angina pectoris…..	Yes
Palpitations……..	Yes

Respiratory

Wheezing…….	Yes
Chronic or frequent coughs…….	Yes
Spitting up blood…….	Yes
Shortness of breath……..	Yes
Sleep Apnea.....	Yes

Gastrointestinal

Abdominal pain……	Yes
Loss of appetite……	Yes
Nausea or vomiting……..	Yes
Painful bowel movements……...	Yes
Diarrhea……...	Yes
Constipation……	Yes
Rectal bleeding or blood in stool……	Yes

Integumentary (skin, breast)

Breast discharge……..	Yes
Change in skin color……...	Yes
Change in hair or nails……	Yes
Varicose veins…….	Yes
Breast pain……..	Yes
Breast lump…….	Yes
Rash or itching…….....	Yes

Neurological

Frequent or recurring headaches…….	
Head injury……..	Yes
Convulsions or seizures……..	Yes
Numbness or tingling sensations.....	Yes
Tremors……..	Yes
Paralysis……..	Yes
Light headed or dizzy……..	Yes
	Yes

Psychiatric

Insomnia…….....	
Memory loss……	Yes
Nervousness……	Yes
Depression……..	Yes
	Yes

Endocrine

Change in hat or glove size…….	
Excessive thirst or urination……	Yes
Heat or cold intolerance……..	Yes
Skin becoming drier……..	Yes
Glandular or hormone problem……....	Yes
	Yes

Musculoskeletal

Joint pain……..	Yes
Joint stiffness……...	Yes
Swelling……...	Yes
Difficulty walking……	Yes
Muscle pain or cramps……	Yes
Back pain……	Yes
Cold extremities……...	Yes
Weakness of muscles.....	Yes

Hematologic/Lymphatic

Slow to heal after cuts ……	Yes
Bleeding or bruising tendency……	Yes
Enlarged glands……	Yes
Phlebitis……	Yes

Genitourinary

Frequent urination ……..	
Burning or painful urination…….....	Yes
Blood in urine…….....	Yes
Straining to urinate ……	Yes
Incontinence or dribbling ……	Yes
Kidney stones ……	Yes
Sexual difficulty……...	Yes
***Male**	
Testicular pain ……	Yes
***Female**	
Pain with periods ……... ……	
Irregular periods ……	Yes
Vaginal discharge ……	Yes
# of Pregnancies _____	Yes
# of Miscarriages_____	
Date of last pap smear _____	

All others Negative:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

NEUROLOGIC ASSOCIATES OF WAUKESHA, LTD.
1111 DELAFIELD STREET, SUITE 105
WAUKESHA, WISCONSIN 53188

NEUROSURGERY
GEORGE R. BARTL, MD, FACS
CHRISTOPHER KING, DO
LYNN M. BARTL, MD, FACS
KENNETH W. REICHERT II, MD
GLENN A. MEYER, MD, FACS
ANDREW V. BEYKOVSKY, MD

Telephone 262-542-9503
Fax 262-542-8447
Refill Line 262-542-9503 select option 3

NEUROLOGY
BRIAN A. CHAPMAN, MD
DARRYL PRINCE, MD
STANYA SMITH, MD
GENEVIEVE JONES, MD

MEDICATION THERAPY AGREEMENT

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2. It is best that all medications you receive come from one pharmacy and ALL controlled substances must be obtained at the same pharmacy for each refill. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:
   Pharmacy: _____
   Phone:_____ **Address:**_____
3. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care, for the purpose of maintaining accountability.
4. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to these medications.
5. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances or lack of the prescribed substance will result in your discharge from this practice.
6. I will not consume excessive amounts of alcohol in conjunction with narcotics, or will I use, purchase, or otherwise obtain any other legal or illegal drugs including marijuana or cocaine.
7. Medications will not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told is not enough.
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11. You will be asked to sign for your prescription at pick up at our office. You will be required to show a photo ID to pick up your prescription. Prescriptions will only be released to you unless otherwise indicated. I give my permission to have (full legal name) _____DOB_____ pick up my prescription. I understand that this person will be required to show a photo ID and sign for the prescription at pick up. Prescriptions cannot be picked up after 4:30 pm daily or 3:30pm on Fridays.

I agree that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms.

_____ _____
Patient's full name (Print) DOB

_____ _____
Patient's signature Date

_____ _____
NAW staff signature Date

USUAL AND CUSTOMARY RATES:
We believe our fees to be fair and reasonable. You are responsible for payment regardless of an insurance company's arbitrary determination of usual and customary. Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company, as we have no authority to act on your behalf. We reserve the right to bill for services not covered by insurance (telephone calls, weekend services and form completion).

INSUFFICIENT FUNDS:
If a check is returned due to insufficient funds, you will be required to pay $25.

MISSED APPOINTMENTS:
In the event that you cannot keep a scheduled appointment, please notify our office at least 24 hours in advance of the appointment, or you will be charged $45 for the visit. This no show fee must be paid in full before your next appointment in order to be seen. Patients that miss frequent appointments and do not follow their physician's requested plan of care may be discharged from the clinic.

PAYMENT OF OUTSTANDING BALANCE:
You will be expected to pay any outstanding balance at the time of service. If you have not made active payments on an account that has aged for three months, **your appointment will be cancelled until an initial 'good faith' payment, plus the co-pay due at time of service is made. If account is in collection, the balance is due.** We do understand the challenges of multiple medical bills. Please contact our Billing Office representatives at (262) 542-9503 Press Option #5 to set up a payment plan that works toward keeping your account in good standing.

REQUEST YOUR INSURANCE COMPANY NOT BE BILLED. If you pay in cash in full (out of pocket) for your visit, the day the service is provided, you can instruct NAW not to share information about your treatment with your health plan for that visit ONLY.

Thank You

for choosing our office for your healthcare needs.

We hope this information assists you in understanding our financial policy and billing methods. We encourage our patients to be active healthcare consumers, understanding and participating in both the medical and financial side of your healthcare experience.

When you adhere to our billing policy, the cost of our billing decreases and it helps us keep our fees reasonable. Understanding our financial policy is an essential element of your care and treatment.

Neurologic Associates Of Waukesha

FINANCIAL

POLICY

Guidelines

To learn more, visit us at www.neurologicltd.com

Thank you for being an active healthcare consumer. This guide is designed to introduce you to our financial relationship as healthcare provider and patient. If you have any questions after reviewing this document, please feel free to call our office at (262) 542-9503 or visit us online at www.neurologicltd.com.

PATIENT RESPONSIBILITY

We encourage patients to play an active role in their healthcare: both medical and financial. It is important for you to understand your insurance policy. We are happy to assist you with questions regarding your insurance, but you are ultimately responsible for payment. Please contact your insurance company if you have questions prior to receiving services to make an informed decision about your healthcare.

REGISTRATION / INSURANCE CHANGES:

It is important that you bring your current insurance card to every appointment. Insurance providers, policies and member identification numbers tend to change frequently; it is your responsibility to communicate any changes in coverage so we may appropriately bill your insurance carrier. Please also advise us of any personal address, telephone and other demographic changes to ensure accurate status of your account.

CO~PAYMENTS (CO~PAYS):

All co-payments (co-pays) are due prior to your scheduled appointment at check-in. We accept cash, check, MasterCard and Visa. If you come for your appointment without your co-pay, your appointment will be rescheduled to a time that better meets your financial needs. . If you have dual private insurance coverage, the lower of the two co-pays will be collected. A refund will be issued if the secondary insurance reimburses the co-payment amount collected.

ADDITIONAL FEES AND SELF-PAY SERVICES:

Fees for medical supplies will be due upon receipt of the prescribed items if not a covered benefit under your insurance plan. Fees for services that are not covered under your insurance benefit plan will be collected at the time of service. This may include injections.

REFERRALS & PRIOR AUTHORIZATIONS:

If you have been referred our specialist office by your primary care physician, you are responsible to confirm insurance coverage and obtain the necessary referral as required of your insurance policy. Your benefits may be significantly reduced if you receive services from us as an out-of network provider so please contact your insurance company if you have questions prior to receiving services. This will allow you to make an informed decision about your healthcare.

PATIENTS WITHOUT INSURANCE:

We are committed to making healthcare more affordable for our patients without insurance. We require a down payment of $150 at the time of service at registration. Additional Services will require advance payment and arrangements with the billing department before services are scheduled.

COMMERCIAL INSURANCE:

We will file to all commercial insurance plans. However, the claim amount due is the patient's responsibility and we will require payment from you for all unpaid amounts.

MEDICARE:

You are responsible for all deductibles, co-payments and non-covered services. Medicare does not pay for certain services (e.g. preventative services and certain injections). In this case, you will be responsible for those services. You may be asked to sign an Advance Beneficiary Notice (ABN) when Medicare will not pay for services. If you have secondary insurance, please provide the billing information (secondary insurance card) and we will be happy to bill your secondary plan.

THIRD PARTY LIABILITY:

If you are being treated for a personal injury (e.g. car accident) and a third party is responsible, the bill for services is your responsibility and full payment is expected at the time of service unless we bill your health insurance. If you have verified health insurance, we will bill your health insurance company and they will work with the liable party to get a settlement. We will only bill the third party if you do not have health insurance, but we do not accept attorney liens or letters of protection. If we do not receive prompt payment from the third party, the bill will become your responsibility and will be billed to you. We cannot accept the responsibility of negotiating a settlement on a disputed claim.

WORK~RELATED INJURY (WORKER'S COMPENSATION):

If you are injured at work, please inform our reception/insurance billing staff when scheduling the appointment as well as the front desk staff when you check in. You will need to complete the NAW Accident Injury questionnaire, bring a copy of your first report of injury and provide all relevant workers compensation information from your employer. We must have your worker's comp claim number. In the event that your employer does not pay the claim, we will bill your health insurance and/or you will be responsible for the charges.

COLLECTIONS:

Representatives in our Billing Office are available to help with payment arrangements to keep your account in good standing. Accounts are to be paid upon receipt of the first statement. Failure to respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. We reserve the right to refuse credit or service to anyone who neglects their financial responsibility and allows their account to become delinquent. If you have an inquiry regarding your account, please contact our Billing Office at (262) 542-9503 and press Option #5. We can help set up a payment plan that works toward keeping your account in good standing.

ESTABLISHING CREDIT:

We will extend credit to you when we have verified your insurance coverage. When your insurance coverage cannot be verified or if your account has ever been placed with an outside collection agency, you will be asked to pay a portion of your visit to establish credit with us.