ARTHRITIS CONSULTANTS, P.C

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Financial Policy

THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR RHEUMATOLOGY NEEDS.

WE ARE COMMITTED IN PROVIDING YOU EXCELLENT CARE.

WE WILL BILL YOUR INSURANCE ON YOUR BEHALF WITH THE INFORMATION YOU HAVE PROVIDED US, THEREFORE PLEASE NOTIFY US OF ANY CHANGES TO YOUR PLAN PRIOR TO YOUR APPOINTMENT. PLEASE BE AWARE THAT YOUR INSURANCE MAY CONSIDER SOME OF OUR SERVICES AS NON-COVERED OR NOT MEDICALLY NECESSARY EVEN THOUGH OUR PROVIDERS MIGHT BELIEVE THEM MEDICALLY NECESSARY FOR YOUR ONGOING HEALTH CARE. THEREFORE, AS OUR PATIENT YOU ARE RESPONSIBLE FOR PATYMENT OF ALL SERVICES PROVIDED BY OUR OFFICE.

ALL CO-PAYS, CO-INSURANCES, DEDUCTIBLES ARE DUE PRIOR TO YOUR TREAMENT AND/OR AT THE TIME OF YOUR VISIT. IF YOU FEEL NECESSARY TO ARRANGE A FINANCIAL AGREEMENT PLAN, PLEASE LET US KNOW SINCE IF YOUR ACCOUNT BECOMES PAST DUE, IT WILL BE PLACED WITH AN OUTSIDE COLLECTION AGENCY AND YOU WILL BE RESPONSIBLE FOR ALL COLLECTION/ LEGAL FEES.

THANK YOU FOR READING AND ACKNOWLEDGING UNDERSTANDING OF OUR FINANCIAL POLICY, PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS AND OUR BILLING DEPARTMENT WILL BE GLAD TO HELP YOU.

NAME OF PATIENT ______________________________

DOB ________________

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY FOR ARTHRITIS CONSULTANTS PC

SIGNATURE __________________________

DATE ____________