FINANCIAL POLICY

This describes our practice's patient payment procedures for all services (i.e. exams, supplies, forms completion, etc) rendered to you. Our practice agrees to file accurate medical claims on your behalf to your insurance carrier(s). **Please read all applicable sections and sign this page for acknowledgement of our practices and for assignment of benefits to our practice.**

PATIENTS WITH INSURANCE: You are expected to provide us with complete and accurate information to ensure appropriate reimbursement for your care. Patients are responsible for any co-payments, deductibles, "non-covered services", as well as any documentation needed to process your claims. Failure to provide valid and required information will result in immediate patient responsibility. Our staff is compliant with all HIPAA regulations.

PAYMENTS: Co-payments are due at the time services are rendered. If you are unable to pay your copay, you may be asked to reschedule or a payment plan may be permitted at our discretion.

NO SHOW/ SAME DAY CANCEL POLICY: If you no show to an appointment without 24 hours notice to our office, you will be charged a $50 fee. If you cancel your appointment with less than 24 hours notice, you will be charged a $25 fee. This policy applies to all patients and is your responsibility; your insurance cannot be billed for this charge. Repeated non-compliance with these policies may result in denial of medication refills and/or dismissal from the practice.

REFERRALS: Valid referrals or authorizations, as required by your insurance carrier, must be received *before* services are rendered; otherwise, your appointment will be rescheduled or you will be required to pay for care at a self pay rate, and your payment will be refunded for any amount more than you are responsible, if the services are paid by your insurance carrier. It is your responsibility to provide the referral to our office.

NO INSURANCE: Payment is expected at the time services are rendered, unless payment arrangements have been established with our practice prior to your visit.

FORMS COMPLETION: Our forms fees are determined based on the complexity and length of the documents that need to be completed; our minimum charge is $15. The fee will be due when you retrieve your forms. Most forms take one week to complete, but this may differ on a case by case basis.

STATEMENTS: Every 45 days, our practice will mail you a statement for any outstanding balances due to our office. Payment is expected within 45 days. Failure to make a payment may result in further collection actions and could postpone your future appointments. If payment problems arise, we encourage you to promptly contact our office.

PAYMENT METHODS: We accept payments by cash, check, MasterCard, VISA, Discover, and AMEX. There is a $25 fee for any bounced checks, and the fee cannot be paid with another check.

AUTHORIZATION/ASSIGNMENT OF BENEFITS: For services rendered to me, I hereby authorize the release of private health information for the purpose of treatment and reimbursement for such care. In addition, I hereby authorize and assign benefits directly to Dallas Rheumatology PLLC. I have read and understand the above described practice payment policies and patient responsibilities pertinent to me (and/or guarantor).

Signature of Responsible Party:____

Print Name of Responsible Party: ____

Date: ____________________________

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