RHEUMATOLOGY CENTER OF SAN DIEGO

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PATIENT FINANCIAL AGREEMENT

1. ____ (initial) **Co Payments:** Your insurance company requires us to **collect co-payments 48h prior your appointment.** Due to State and Federal laws, co-payments will not be waived. Returned checks: a fee of $40 (forty dollars) will be assessed, and must be paid in cash, money order or by credit card within 15 days of receipt of our notice.
2. ____ (initial) **Claims Submissions:** As a courtesy we will bill your insurance.
   a. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until the claim is resolved. Payment from your insurance company is usually expected within 45 days. After 45 days**, we may look to you for full payment**.
   b. You are responsible for all non-covered services according to your insurance's guidelines.
   c. If we received notification that you are not eligible for coverage or we are not contracted with your insurance, **you will responsible for all charges** incurred and payment is due upon receipt of the bill.
   d. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. If you have an HMO plan you are responsible for obtaining <u>referrals from primary care physician prior to the appointment</u>.
   e. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans.
   f. Accounts that are more than 90 days past due will be referred to a collection agency. You will be assessed a Collection Recovery Fee of $40 (forty dollars) in addition to your outstanding balance. You will be responsible for any fees assessed by the collection agency (i.e. attorney's fees, court costs, and collection agency fees). There is also a Monthly Billing Fee of 1% per month, 12% annually.
3. ____ (initial) **Ancillary Services:** Laboratory and radiology procedures will be billed separately by an outside provider. Please contact them directly should you have any questions regarding your bill.
4. ____ (initial) Missed appointments**: If you cancel an appointment less than 48 hours prior to the scheduled time or do not show up for your appointment, you will be billed a cancellation/no show fee of $50 (fifty dollars).** Additionally, if I do not show to three appointments you may be discharged from the practice. **Medical insurance plans do not cover missed appointments.**

Private Pay Patients : For new patients **$260** (two hundred and sixty dollars) is expected upon check in. Follow-up visits; must be prepared to pay **$160** (one hundred and sixty dollars) at the time services are rendered.

Please confirm your appointment within 48 hrs. Your appointment may be cancelled if you do not confirm within 48 hours of your scheduled time.

Patient's Signature and Printed Name ______________________________ Date ______________

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Printed Name (if Signed on Behalf of Patient) Relationship Date

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