FAMILY ARTHRITIS CENTER

PATIENT REFERRAL AND FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Family Arthritis Center as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient referral and financial policies, which are as follows:

• The patient is ultimately responsible for obtaining the **referral** from their primary doctor if required by their insurance company and providing it before or at the time of visit.

• The patient is responsible for charges associated with Insurance **co-pays, deductibles, co-insurance** and/or non-covered charges.

• The patient is ultimately responsible for the payment of his/her treatment and care if a referral is **not** provided as requested and your claim is being denied or your insurance plan is not valid.

• The patient is responsible for all balances on their account and all fees associated with collection action if patient fails to pay PLUS 1.5% interest.

• The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency).

• We reserve your appointment time especially for you. A 24-hour notice of rescheduling or cancellation is REQUIRED. We reserve the right to charge you for a NO SHOW or CANCELLED appointment the same day of the visit. This charge will be **$50** for a follow-up appointment, DEXA, injection, or infusion; and **$100** for a New Patient appointment. We are aware that emergencies can arise, but repeated cancellations and no shows will result in DISMISSAL from the practice. Confirmations are a COURTESY; therefore, you are expected to remember your appointments.

• By my signature below, I hereby authorize assignment of financial benefits directly to Family Arthritis Center and associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Referral and Financial Responsibility Form:

Signature of Patient or Guardian: _____Date: _____

Name of patient: _____

Waiver of Patient Authorizations:

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible of charges and to submit claims to my insurance company at my discretion.

Signature of Patient or Guardian: _____Date: _____

Name of patient: _____