HOWARD RHEUMATOLOGY

FINANCIAL AGREEMENT

My initials indicate that I have read and agree with each item below.

Professional Fees:

PATIENT NAME: _____

Special financial arrangements must be discussed at the first appointment with Dr. Howard. Dr. Howard and Howard Rheumatology does not participate in any insurance plans including Medicare and therefore I agree to pay the following:

_____ Physician Services

_____ $25 processing fee for any returned check.

_____ Collection/ legal fees if account is referred to a 3rd party collection agency.

_____ SELF PAY fees may include charges for the other professional services such as

1. Report writing
2. Preparation of records or treatment summaries
3. Legal proceedings, including preparation time and transportation
4. Above fees will be discussed in advance.

Payment for Service

_____ It is my responsibility to know what services are covered by my insurance plan, I have reviewed carefully the section in my insurance coverage booklet that describes mental health services. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or denied by my insurance plan.

_____ I will provide full and accurate insurance information in advance of my appointment and will pay for the appointment on a self pay basis. I will present my insurance card at the time of my appointment. I will provide updated insurance information promptly in case of any changes.

_____ I understand that I, not my insurance company, am responsible for full payment of my fees.

_____ I understand that, if I do not pay any remaining balance within 30 days, I maybe charged a $20.00 late payment fee. This fee will also be subject to and in addition to any collection fee charged by our 3rd party collection agency if it is necessary to refer my account to a 3rd party collections agency.

Policy for Missed Appointments and Cancellations

_____ I agree that I must give at least **24 hour notice** in advance to avoid a late cancellation or no show fee of $100.00 for Doctor visit and treatment.

I HAVE READ THIS FINANCIAL AGREEEMNT, ASKED ANY QUESTIONS I HAVE ABOUT IT, AND AGREE TO ITS TERMS.

Patient or Parent/Guardian Name in Print _____

Patient/Parent/Guardian Signature _____ Date _____