PATIENT FINANCIAL RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**

   I understand that I am financially responsible for my health insurance deductible, coinsurance, or any non-covered services. Co-payments are due at the time of service. If my plan requires a referral, I must obtain it prior to my visit.

   In the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

   I hereby authorize and direct payment of my medical benefits to **ARIZONA RHEUMATOLOGY CONSULTANTS, PLC** on my behalf for any services furnished to me by providers.

3. **AUTHORIZATION TO RELEASE RECORDS**

   I hereby authorize **ARIZONA RHEUMATOLOGY CONSULTANTS, PLC** to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnoses and the records of any treatment or examination rendered to me, needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical providers.

4. **MEDICARE REQUEST FOR PAYMENT**

   I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by **ARIZONA RHEUMATOLOGY CONSULTANTS, PLC**. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

5. **NO-SHOW AND CANCELLATION POLICY**

   I acknowledge and understand that if I fail to cancel or reschedule my appointment at least **one (1) business day** prior to the scheduled time, I will be charged a **No-Show Fee** as follows:

   - **New Patient Appointments:** $100
   - **Follow-Up Appointments:** $50

   This fee is applicable except in cases of emergencies.

Signature of Patient, Authorized Representative, or Responsible Party

Print Name of Patient, Authorized Representative, or Responsible Party

Date

Relationship to Patient