Arthritis Center

3440 DePaul Lane Suite 113
Bridgeton, MO 63044

Phone: 314-942-6464
Fax: 314-492-4636

Statement of Consent for Treatment

As the Patient/Guardian, I consent to medical treatment considered necessary to correct an immediate medical problem, and that such treatment and procedures (i.e., Labs, Ultrasounds) will be performed by medical practitioners who are staff members of the Arthritis Center. The undersigned hereby consents and grants authorization for such treatment and certifies that no guarantee or assurance has been made as to the results of such care. I authorize the Arthritis Center to release any health or financial information requested by my insurance company(s) or other third-party payers in connection with this assignment. I do hereby appoint the Financial Manager of Arthritis Center as my lawful attorney to endorse for me any checks payable to me for debts or claims collected under this assignment and to apply any credit balance to any other debt, I may owe to Arthritis Center.

Statement of Financial Responsibility:

All services rendered are the financial responsibility of the patient. We will bill your insurance(s), however the patient is responsible for all fees, regardless of insurance coverage. This includes the usual and customary fees applied by your insurance company. If your account reaches collection status, your account will be locked, and our office will be unable to process prescription and/or appointment requests. Your account will be assessed an additional $50 fee should it be sent to an outside collection company. You will be required to pay the collection balance plus the $50 fee before future care is administered.

As of January 1st, 2025, Due to an increase in patients wanting to schedule appointments with our office, we ask that you respect our no call/no show policy. We require a 24 notice to cancel or reschedule your appointment. Should you fail to call, your account will be charged a $50 no call/no show fee. Should you want to be seen at a later date the no call/no show fee must be paid AND a credit/debit card must be placed securely on file. Arthritis Center guarantees only ONE paper statement will be sent to you regarding patient balances. Additional notices regarding your account balance will be sent electronically via email, where you will be given the opportunity to pay your balance via a secure online portal. We ask you to provide a valid email to be on file and that you notify our office should this email address be changed.

Code of Conduct for all Patients/Visitors:

Arthritis Center expects patients and visitors to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights and safety of other patients/staff. If you have questions about the care, contact our practice manager. The Arthritis Center follows a zero-tolerance policy for aggressive behavior directed by patients/visitors against our staff.

Consent for Appeal:

I, with my signature, authorize (Arthritis Center), and any employee working under the direction of the physician to appeal any insurance claims/prior authorizations that are denied on my (the patient's) behalf regarding medication, medical devices, and/or medical procedures prescribed by the physician.

By signing below, you are acknowledging you understand and agree to all above statements.

Patient Signature: _____ *Patient Date of Birth* ___/___/____

Patient Printed Name: _____ *Date:* _____