**Patient Financial Responsibility Agreement**

**Welcome to Central Bucks Rheumatology.** We are committed to providing you with quality healthcare. Please understand that payment of your medical expenses is part of your treatment and care. Please read these policies and feel free to ask us any questions you may have regarding these policies.

Financial Responsibility:

It is important for you to understand that you, the patient, are ultimately responsible for payment of medical services you have received. Cash, personal check, and credit cards are all accepted in our office.

Proof of Insurance:

We must obtain a copy of your driver’s license or photo ID and current, valid insurance card(s) to provide proof of insurance. If you fail to provide us with the correct insurance information at each visit, you may be responsible for the balance of the claim for your visit.

Co-payments and Deductibles:

All co-payments and outstanding deductible balances must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to collect co-payments and deductibles from patients can be considered a breach of contract and may result in the rescheduling or cancellation of your appointment.

Referrals:

If you have an HMO insurance policy, you will require a referral from your primary care physician in order to be treated in our office. You are responsible for obtaining the referral authorization from your primary care physician prior to your appointment. Most primary care offices ask that you give at least 72 hours-notice for a referral request. If a referral is required but not available on the date of your visit, you may be asked to reschedule your appointment. If you choose to be treated without a referral, you will be responsible for the entire cost of the visit.

Non-Covered Services:

Please be aware that some, and perhaps all, of the services you receive may not be covered or considered “reasonable” and “necessary” by your insurer. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary as part of your medical treatment. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your physician might decide that you need medical care that is not covered by your insurance policy. It is your responsibility to understand the terms of your individual insurance plan and the services which are covered and are not covered or have limited coverage. You may be responsible for payment of any services considered not covered by your insurance plan.

Past Due Balances:

Any balance more than 30 days old will be considered past due. Once a balance is past due, payment will be required before your next visit in the office. Failure to make a payment on a past due balance before your next scheduled appointment may result in the cancellation of your appointment. Payment in full is due upon receipt of our statement. Accounts with remaining balance will be sent to an outside collection agency after 120 days. Accounts that have unpaid balances could potentially impact your credit score.

Returned Checks:

Checks written at the time of your visit or mailed as payment on an account balance that are returned by the bank will be assessed a $50.00 returned check fee. If the original check amount plus the returned check charge is not paid within 15 days, your account will be considered for transfer to a collection agency.

Request of Medical Records:

For personal requests, there will be a fee for retrieval and printing of the records, which will be determined upon the number of pages in the medical records. Transfer of records from our office to another physician will not incur a fee.

Request Completion of Forms by Physician:

A $15.00 fee will be assessed for physician completion of disability/FMLA forms. Payment is due at the time of the request. Completion may take up to 2 weeks. Completed forms will be mailed to the patient, or may be picked up in our office during normal business hours.

I acknowledge that I have read and understand these policies and agree to the terms and conditions within.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Caregiver Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_