ADVANCED RHEUMATOLOGY

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FINANCIAL POLICY & GUARANTEE OF PAYMENT FOR SERVICES

Thank you for allowing us to be part of your health care team. In order for us to provide the best possible care and to maximize your medical insurance policy coverage, you must provide accurate insurance information. This includes providing current insurance card(s) and informing our staff of any recent changes, including employment, coverage, or address.

In the interest of providing you with uninterrupted quality medical care, we are advising you of the following:

- The relationship you have with your insurance company and employer is a contract of which we are not part of. As a courtesy, our billing staff will process your claims for you, and answer any questions you may have. Please be advised that, regardless of your insurance status, final responsibility for payment of our services is your obligation.
- There are some insurance companies that require an authorization before an office visit will be paid; others have their own insurance guidelines about when a visit to a specialist's office will be covered. **It is your responsibility to know the extent of your insurance benefits and to get any required authorizations in advance of being seen.**
- We will make every attempt to notify you of your insurance coverage for our services. However, we cannot guarantee coverage for every service. Certain services, such as injections, test and medications may not be covered by your insurance.
- Co-payments are due at the time of service. If you cannot pay the co-payment today, please notify the receptionist.
- If, for any reason, your insurance company chooses not to cover your office visit or any procedures, you will be responsible for payment at the time of service. This includes all future visits. The estimated cost for a visit can be provided to you in advance.
- Your signature below indicates that you will be responsible for payment in full should you fail to obtain an authorization, or should your insurance company choose not to pay for your visit.
- You authorize the release of any medical information necessary to process my insurance claim to Dr. Mohan and authorize payment of medical benefits be made to them for services rendered, when they request those payments to be made directly to them.

I, _____ , have read and agree with the above statement, and further agree to be responsible for all charges incurred, or to provide written approval authorization from my insurance company for all visits and procedures prior to being seen.

_____ _____
Patient signature Date

_____ _____
Parent or Guardian signature, if applicable Date