ARTHRITIS ASSOCIATES CLINIC POLICIES

Welcome to our clinic. We appreciate the opportunity to work with you. The following is provided for your benefit so that we may serve you better.

Initials:

_____ 1. PAYMENTS- All applicable fees, deductibles, coinsurance, or co-pays, must be paid at the time of your appointment. We accept cash, checks, VISA, MasterCard or Discover. There will be a $25.00 charge for all returned checks. Patients who present checks which are dishonored will be required to pay future amounts due with cash, money orders, or credit cards.

_____ 2. CANCELLATIONS- If you need to cancel and reschedule your appointment, be sure to call us at least 24 hours before your scheduled appointment. You will be charged for the visit for late cancellations or missed appointments unless you had an emergency.

_____ 3. HMO & PPO REFERRALS- If your policy requires written authorization (referrals or pre-certifications) from your Primary Care Physician or PPO, we require that we have this authorization on file in our office before we schedule your appointment. If is ultimately your responsibility to make sure that your visit is pre-approved and you insurance company will pay, or you will be responsible for payment in full.

_____ 4. MEDICAL RECORDS- If you require any forms to be completed by your physician or our staff, or photocopies of your medical records (2nd request), you (not your insurance company) will be charged.

_____ 5. OFFICE COURTESY- Do not bring any food or drinks into the clinic. Child care is not provided for children. Please do not leave children unattended in the reception area.

_____ 6. YOUR ATTENDING PHYSICIAN- Once you have selected or been assigned to a Physician, he or she will be your Attending Physician throughout you treatment here at the clinic. If, during the course of your treatment, your Attending Physician is temporarily unavailable, another Physician may treat you in his or her absence, but you will return to the care of your Attending Physician upon his or her return.

_____ 7. MEDICATION REFILL REQUESTS- You must request any refills at the time of your office visit. If any refills are needed otherwise, you must contact your pharmacy.

_____ 8. LAB TEST RESULTS- You will be notified of any lab results that need immediate attention. Otherwise, your Attending Physician will discuss your lab results with you at your next office visit.

_____ 9. FINANCIAL RESPONSIBILITY- By signing below, I am authorizing my insurance company to assign any and all benefits and payments for services rendered, to Arthritis Associates, P.A.

_____ 10. PATIENT RESPONSIBILITY- If, for whatever reason, my insurance company refuses to pay for any, part, or all charges resulting from medical services received, I will be responsible for timely payment. I also understand that it is the patient's responsibility to give updated information on all insurances.

_____ 11. IDENTIFICATION- It is mandatory for the Arthritis Associates, P.A. to obtain the patient's Social Security number in order to identify the patient with insurance companies, laboratories, or any diagnostic testing. Please be assured that any and all personal information is kept confidential and is properly destroyed when necessary. A copy of your Driver's License/State I.D. is needed only at the initial office visit. A copy of your insurance card is need at every office visit to maintain accurate verification of benefits and coverage.

"I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

_____ _____

Signature Date

_____

Printed Name