

## **Arthritis and Joint Center of Florida Financial Policy**

We are committed to providing the best care at the most reasonable cost. We take every opportunity to keep costs down without sacrificing your quality of care. With this in mind, we would like to share our financial policy with you to prevent any misunderstandings. We hope you will consult with us if you have any questions regarding our services or financial policies.

### **Patient Billing/Insurance**

We accept most major insurance carriers; please ask if you have questions. Our participation is subject to change. We do not accept third party insurance such as worker's compensation or auto insurance (PIP). Fees for services are due at the time the services are rendered. All co-pays are collected upon arrival, prior to seeing the physician. If you are unable to pay at the time of service, you will need to either work out a payment plan with our billing department or reschedule your appointment.

As a courtesy to our patients, we accept and file claims for numerous insurance plans. However, we do not always know in advance how each insurance carrier will reimburse for procedures. A carrier will send you an Explanation of Benefits letting you know how much they paid and whether or not there is an additional balance. It is important that you understand your insurance plan. You are ultimately responsible for your fees and if your carrier does not cover your fees as expected, you will receive a bill for the outstanding balance from our office. (If your Explanation of Benefits shows a balance due, this is not necessarily what you owe us. Please wait until you receive a statement from us to send payment.) Please call your insurance carrier if you have questions about your coverage—we recommend you get the name of the person to whom you speak in case you need to follow-up.

In some cases, your insurance company will require prior authorization before you can come in either for an office visit or a particular procedure. When possible, we will get the authorization for you and give you a rough estimate of how long it will take. Please keep in mind that this process could take weeks depending on the particular carrier and procedure. We do our best to do this for you as quickly as possible but remember that we have no control over how long your insurance company takes to get back to us.

If our office refers you to another physician or facility, we will obtain prior authorization if one is required.

## **Self Pay or No Insurance**

Patients without insurance coverage will be asked to make the full payment at the time of service. If there are additional services beyond what was estimated for that visit, the patient may receive an additional bill for the balance.

A patient may speak with the business manager or billing director to work out a payment plan.

## **Insurance Filing**

We will file all claims for patients' primary and secondary insurance carriers, provided we have the correct information. If your claims are rejected even after we have corrected any known errors, you may receive a bill for the outstanding balance and will be responsible for filing a claim for reimbursement with your carrier.

Payments should come directly to our office. If, for some reason, the payment comes to your home, please drop it off or mail it to us.

## **Outstanding Balance**

Although office co-pays are collected at the time of service and insurance claims are filed in a timely fashion, sometimes your insurance carrier follows a different fee schedule. We do our best to find out for you beforehand, but it is possible that you may have a balance. IN OTHER WORDS, THE AMOUNT YOU PAY DURING YOUR VISIT MAY NOT BE ALL YOU OWE.

Unless otherwise stated by your insurance company, most insurance carriers have:

- Co-payment for office visits
- Encounter fees
- Yearly deductibles/annual out of pocket fees
- Services must meet medical necessity guidelines
- Guidelines for services covered.

Patients who have not made an effort to make or maintain payment arrangements or have not expressed an interest in meeting their financial obligation may be assessed 1.5% finance charge after 90 days. Any outstanding balance must be paid in full before any additional services will be rendered.

## **Non Payment**

We are proud to offer the highest quality medical service accompanied by great customer service. We are willing to work out a reasonable payment plan with you. However, if after repeated tries to collect payment from you, we do not receive any payment, we reserve the right to flag your record as non-compliant after 120 days.

As a non-compliant patient, we reserve the right to legally release you from our care.

### **Payment Options**

For your convenience, we accept Visa, Mastercard, cash and checks. We do not accept American Express or Discover Card at this time. If your check is returned for insufficient funds you may be subject to a \$25 rebilling fee and/or bank charges and will be asked for Mastercard or Visa to make your next appointment. The credit card will only be charged if the appointment is missed.

### **Litigation**

We would like to emphasize that as a medical office we work to create a trusting relationship with you, not your insurance company. This office does not participate in patients' litigation. This office will not be available or required to give opinions in reference to your condition including, but not limited to depositions, hearings, testimony, and/or trials.

Correspondence services, such as copies of medical records, letters, forms, and phone calls with you, or on your behalf, may be performed upon your request or as required for your care. You, or the receiving party, will be billed for such services.

### **Questions?**

If you still have questions, please address them with the Billing Director or Business Manager. Please do not ask your provider financial questions during your visit, they cannot address these issues.

## **Acknowledgement of Receipt of Notice of Financial Policies**

It is the policy of the Arthritis and Joint Center of Florida to maintain the privacy of all patients' transactions. The Arthritis and Joint Center of Florida and its representatives are hereby authorized to release any medical or incidental information that may be necessary for either medical care or in processing requests for financial benefit. A copy of our Privacy Policy and Financial Policies are available for your review.

I, \_\_\_\_\_, have received or read a copy of the Arthritis and Joint Center of Florida's Financial Policy.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date