

## Financial and Office Policy

### Insurance:

As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you.

### Financial Arrangements:

Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards and checks. (**returned checks will be subject to a \$35 returned check fee**). If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment.

### Deductibles and Co-pays:

Full payment is due at the time services are rendered. This includes co-payments, deductibles and services not covered by your insurance. If you are on a high deductible plan we collect \$200 for new patients and \$150 for established patients until the deductible has been met. If you are not able to pay your co-pay or deductible you may be asked to reschedule your appointment.

### Appointments/Cancellations:

We gladly reserve appointment times for you and appreciate that you have chosen Arogya Rheumatology PLLC for your care. As a courtesy, we will remind you of your appointment by calling and/or text/emailing you prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. **We reserve the right to charge \$50 for regular appointments for canceled or broken without advance notice of 2 business days.**

### Late Fees:

I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or \$35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

### Assignment and Release:

I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

### Prescription Refills:

We only provide prescription refills during an office visit with a physician. We require office visits on a regular basis for all patients taking prescription medications. Please bring all prescription bottles and a current detailed medication list with you to your appointment.

### Credit Card on File Policy

Arogya Rheumatology PLLC is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. We will scan your card with a card reader. It will store your card number in a secure, compliant location. For security reasons only the last four digits will be visible to our staff. Credit cards on file will be used to pay copays when you are seen in our office, including account balances, after your insurance processes your claim.

If we do not receive payment for the amount listed on your statement within 13 days, we will run the credit card on file for the full amount owed. If your payment is declined, we will call you. If our reminder call is not returned within one week, a \$35 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. The unpaid balance will be subject to a finance charge of 1.5% (18% APR) or \$35, whichever is greater. Further delinquency will be subject to collections with additional finance fees.

I give Arogya Rheumatology PLLC permission to charge my credit card for any patient balance due on my account.

**Dismissal:**

If you are 'dismissed' from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.

**Common Reasons for Dismissal:**

- failure to keep appointments, frequent no-shows
- non compliance, which means you won't follow physician instructions about an important health issue
- abusive to staff
- failure to pay your bill

**Dismissal Process:** We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

**Acceptance:**

I have read, understand, and agree to the provisions of Arogya Rheumatology PLLC Patient Financial and Office policy.

**Name (please print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Responsible Party (Guarantor):** \_\_\_\_\_

**Relationship to Patient(s) (please check):** \_\_\_ Self \_\_\_ Other: \_\_\_\_\_

**Note:** The patient (or Guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.

*Thank you for understanding our office policies. We are excited you chose Arogya Rheumatology PLLC for your rheumatology care.*

### Notice of Privacy Practices

**Notice of Privacy Practices Written Agreement:**

I have read a copy of Arogya Rheumatology's Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Arogya Rheumatology PLLC has a link to the Notice of Privacy Practices on the practice website located at [arogyarheumatology.com](http://arogyarheumatology.com)

**Name (please print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Responsible Party (Guarantor):** \_\_\_\_\_

**Relationship to Patient(s) (please check):** \_\_\_ Self \_\_\_ Other: \_\_\_\_\_