Advanced Rheumatology Associates
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Office and Financial Policies

Welcome and thank you for choosing **Advanced Rheumatology Associates** for your rheumatology needs. We look forward to serving you and strive to provide you with the best quality of care. Please carefully review the following information as it is intended to serve as your guide to a smooth and productive visit.

Initial_____ **Insurance:** When making an appointment with one of our physicians, it is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires a referral and you or your provider does not provide one by the scheduled appointment time, please be prepared to pay for your visit in full or reschedule.

Initial_____**Non-covered Services:** An Insurance waiver may be required to acknowledge understanding of your responsibility for paying non covered services depending on your plan. If your visit is for non-covered services, please be prepared to pay for your visit in full.

Initial_____**Check -in:** Your time is very important to you and us. It is extremely important that you provide each piece of information that is requested on both the patient information and medical history forms. This will avoid delays in creating your chart and account at your visit. Please arrive at least 15-30 minutes prior to your scheduled time so that all the paperwork may be completed before you see the physician. **You must present your current insurance card along with a valid picture I.D. in order to verify your identity.** This will ensure that that all information is entered accurately. On each follow up visit you will be asked to verify demographic and insurance information so that all records remain up to date. **All copays will be collected at the time of check-in.**

Initial_____**Check-out:** Please note that payment of all copays/deductibles is due at the time of service. Typically, only an office visit charge is covered by your copay and any additional services or treatment are subject to your plans specific details.

Initial_____**No Show fee and late cancellations:** In order to be respectful of the medical needs of other patients, please call our office promptly if you are unable to keep your appointment. This time will be given to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **48 hours** in advance. Our staff calls to confirm your appointment as a courtesy, at that time you can cancel or reschedule as well. **A Follow Up "no-show" will result in a fee of $50.00. A New Patient "no show" will result in a fee of $100. This fee must be paid before making the next appointment.** If three **(3)** appointments are missed, you will no longer be considered a patient of this practice. After your third missed appointment, you will be notified by mail to find another Rheumatologist. We will continue to care for you over the next 30 days for emergencies only.

Initial____**Cell/Home Phone Communication:** Any calls will be made to the primary phone number **Advanced Rheumatology Associates** has on file for me. I understand that my primary number may be a cell/home phone number. In such case, I hereby authorize **Advanced Rheumatology Associates** to call my cell/home phone for billing and/or health care matters.

Patient Name : _____DOB :_____

Responsible Person 's signature:_____ Date:_____