arthritis CARE
RHEUMATOLOGY CARE | RESEARCH

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Patient Acceptance of Financial Responsibility

Arthritis Care and Research Center, Inc will bill your insurance as a courtesy. However, you are responsible for all charges for services rendered. In the event services rendered are not covered by your insurance company, we require that you remit payment to Arthritis Care and Research Center, Inc (ACRC).

Additionally, if your insurance provider does not remit payment in a timely manner (within 60 days your insurance is billed), we will transfer balance to your responsibility and require you to remit payment to ACRC for all outstanding insurance balances over 60 days. The outstanding balances may include, but not limited to

* Office visit co-payments
* Annual deductibles
* Services that are not covered by your health plan
* Administrative charges not paid at the time of your service
* Interest charges for overdue patients charged as per California law

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies that will be provided to you. As a courtesy, we will contact your insurance company for authorization for services. However, it is your ultimate responsibility to understand what your insurance company covers and assure that you have authorization for services. We may request your assistance in following up with our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment and expedite payment for your services.

We frequently experience difficulty with insurance plans. Our policy is that we will bill your primary and secondary policies. If you do not receive payment within 60 days we bill your insurance company and we will transfer the balance to your responsibility and require that you remit your payment to ACRC. To prevent this we suggest for you to communicate with your insurance company to assure that they are paying for the services we render. In addition, should our billing office contact you for assistance in obtaining payment for your insurance, your prompt response to their calls would be appreciated.

You will be charged for a missed appointment charge of $25.00 for all appointments that you miss and fail to give at least 24 hour notice.

I understand and agree that I (or the named below who is financial responsible for me) am financially responsible for my services rendered and will pay my outstanding balance within 10 days of receipt of my monthly statements.

_____
Print Patient Name

_____
Responsible Party Name

_____
Patient' Signature

_____
Responsible Party's Signature

_____
Date