East Bay Rheumatology Medical Group, Inc.

FINANCIAL POLICY

Thank you for choosing us as your health care providers. The following statement is our financial policy. Your agreement to this policy is required prior to any treatment. The parent or legal guardian is responsible for payment at the time of the visit. Please acknowledge each statement below by initialing on the line

_____Payments are due at time of service, this includes, self- pay, co-pays, deductibles, non-covered and out of network services.

_____We accept VISA, MASTERCARD, CASH OR CHECKS. Positive ID is required for all credit card or check payments. There is a $25.00 fee for all returned checks.

INSURANCE

_____It is your responsibility to ascertain that your medical provider is a participating provider with your insurance company.

_____If we are not in network with your insurance company, you are responsible for filing the claim with your insurance company, and payment is due at the time of service.

_____A current insurance card and positive identification is required at each visit. Failure to provide the required information will result in forfeiture of the scheduled appointment unless cash or credit card payment can be made for the total charges of the visit.

_____You are responsible for verifying benefits and coverage prior to any visits so that you are not billed for unanticipated charges. Some insurance companies do not cover some routine and non-routine services. Non-covered services will be billed directly to the patient.

_____All outstanding balances that have not been paid within 60 days will be billed to the patient and must be paid by 90 days of date of service regardless of the insurance status. **Unpaid patient balances older than 90 days will be turned over to our collection agency.**

I have read the above financial policy and I understand and agree to its terms and allow the medical providers to treat me.

I_____ have received a copy of this document,
PLEASE PRINT NAME

X_____ DATE_____