ARTHRITIS CENTER *of* ORLANDO
1550 Citrus Medical Ct Ocoee, Florida 34761 P 407 757 0277 eFax 877 6720572

Patient Contract

• I understand that I am responsible for notifying Arthritis Center of Orlando any changes in personal or insurance information as promptly as possible. _____ (INITIAL)

• I understand that I am responsible for payment/re-filing of all services filed to the incorrect insurance company due to my failure to notify the practice of changes in insurance coverage. _____ (INITIAL)

• I understand that I am responsible for the payment of all co-payments, co-insurance, and deductible amounts at the time of service unless other payment arrangements have been made in advance. _____ (INITIAL)

• I understand that I will be charged, and I agree to pay a $25.00 no show fee for any appointment missed without notice of cancellation (a 24-hour notice is appreciated). _____ (INITIAL)

• I understand that I will be charged, and I agree to pay a $50.00 no show fee for any procedure appointment missed without notice of cancellation (a 24-hour notice is appreciated). _____ (INITIAL)

• I understand that three (3) or more missed appointments will result in both the no show fees and possible dismissal from the practice. _____ (INITIAL)

• I understand and agree to pay a $35 returned check fee for any check denied for payment by my bank. I further understand that I will lose check-writing privileges at Arthritis Center of Orlando once a check is denied for payment. _____ (INITIAL)

• I understand that Arthritis Center of Orlando **does not** process RETRO-AUTHORIZATIONS for HMO insurance policies. I understand that it is my responsibility to know the requirements of my insurance policy and notify Arthritis Center of Orlando, **2 business days prior** to any appointments/procedures requiring a referral or pre-certification. _____ (INITIAL)

• I understand that Arthritis Center of Orlando does not process prescription requests on weekends or after office hours on weekdays. _____ (INITIAL)

• In order for Arthritis Center of Orlando to processes prescription requests, please call your pharmacy first. If you have no additional refills and need to contact our office, please allow **2 business days prior** to request prescription refills _____ (INITIAL)

• I understand that I am responsible and agree to pay all collection and attorney's fees resulting from my failure to pay any outstanding balances in a timely manner. _____ (INITIAL)

• I understand and agree that I will be charged a fee for any FMLA, Disability or any other paperwork.

I have read and understand the above contract and agree to abide by the policies outlined above.

Signature: _____ Date: _____