Arthritis Center of Orlando
1550 Citrus Medical Court
Ocoee, FL 34761

Financial Policy

Welcome and thank you for choosing Arthritis Center of Orlando for your medical care!

We are committed to providing you with the highest quality care and achieving desired outcome through a collaborative effort with you, our patient.

It is important that you understand our financial policy but equally important that you understand the terms of your medical coverage. Although our staff is very knowledgeable about the various insurance plans with which we participate, you are in the best position to understand the detailed terms of your specific plan. Typically, your insurance carrier provides you with specific benefit questions or concerns you may have regarding your coverage.

Our professional fees have been determined through careful consideration of reasonable and customary charges within our geographical area. We are always happy to discuss with you any questions you may have concerning a bill.

INSURANCE

Please remember that your insurance is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment for services from the insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.
It is your responsibility to provide all necessary insurance eligibility, identification, authorization, referral information and to notify our office of any information changes when they occur. Even a pre-authorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

UNINSURED PATIENTS

If you do not have medical insurance, we will extend cash pay rates to you. These rates are only if payment is made in full at the time of service.

GENERAL

- Please be prepared to pay the current visit as well as any past due balance on your account at the time of service unless payment arrangements have been made with the billing department prior to your visit.
- If the patient is a minor, the parent(s) or legal guardian(s) are responsible for payments. In cases where a written court document allows payment for medical costs it is the accompanying parents' responsibility to obtain reimbursement from the other party involved.
- Social Security Numbers are a necessary part of your financial information with our office. This information, as with any of your medical record, is protected with strict confidentiality. We are extending a line of credit by filing insurance for your charges and not collecting in full at the time of service, therefore we must have this information. If you do not wish to provide your social security number we will require payment in full at the time of service.
- Balances that remain outstanding more than 60 days after the date of service (or payment by your insurance carrier) will result in a disruption of immunotherapy services and the cancellation of upcoming appointments. The balance may also be considered for referral to an outside collection agency.

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- Accounts referred to an outside collection agency or attorney may be subject to a collection fee, which will be added to the original balance.
- Patients with unpaid delinquent accounts or accounts that have been sent to an outside collection agency will be expected to pay their account in full prior to being seen for a non-emergent visit.
- A $40 fee will be assessed for any returned checks, plus any bank fees. We will require all future payments by cash, cashier's check or debit/credit card.
- A $100 fee will be applied to new patient accounts for no shows and cancellations with less than 24 hour notice.
- A $35 fee will be applied to established patient accounts for no-shows and cancellations with less than 24 hour notice.
- A $50.00 no show fee for any procedure appointment missed without notice of cancellation of less than 24 hours.
- A $10.00 fee per prescription is payable for re issue of lost prescriptions.
- Our office is not party to your divorce decree. The financial responsibility for minors rests with the parent who signs this financial policy.
- **CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT**
- I authorize my insurance company to pay Arthritis Center of Orlando any medical benefits due me for their services. I understand I am responsible to pay deductibles, co-pays and other charges not paid by my insurance company. Our policy is that payment is expected in full at time services are rendered, unless other financial arrangements are made in advance. If you participate with one of our contracted insurance programs, we will bill your insurance. Therefore, verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary. A

FORM COMPLETION AND FEES

We understand that there may be times when you need a form completed by your physician (i.e. medical leave, disability forms). We are willing to assist you with these requests. These forms require research and time on the part of the staff and physicians. The volume of requests and complexity involved make it difficult to complete them at the time of your visit. We ask that you allow 7-10 business days for completion of these requests. Based on the amount of information requested, fees will be discussed prior to completion.

MEDICAL RECORDS

A medical records release form must be filled out for the release of any medical records. Records released to the patient can be provided for a fee of $1.00 per page for the first 25 pages and .25 cents for each page thereafter.

I HAVE READ AND AGREE TO ACCEPT THE FINANCIAL POLICY(S) AS WRITTEN

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Patient Name **Patient Signature** **Date**