INSURANCE & PAYMENT POLICY

BREVARD RHEUMATOLOGY & ARTHRITIS CENTER

We are committed to providing you with high quality medical care. We will facilitate the handling of your medical claims by completing insurance forms for you and accepting direct payment from your insurance carrier. In order to service your insurance needs, we require your understanding of our payment policy.
Please realize that:
1. We cannot guarantee that your insurance will pay your claims. It is your responsibility to know your coverage based on your insurance plan. If your plan requires a referral from your primary care physician, it is your responsibility to provide the referral or payment must be made up front.
2. You are expected to provide complete and accurate information; this includes your full name, address, home telephone number, date of birth, social security number, photo ID and your most up to date insurance card. Our staff is fully compliant with all the Health Information Portability and Accountability Act (HIPPA) regulations.
3. It is our policy to bill your insurance carrier and to collect any co-pay and coinsurance payments or the full fee if self-paying at the time of service. After the claim has been processed and the insurance company has paid their portion of the claim, the balance will be the patient's responsibility. At this time a statement will be generated and mailed to the patient. The patient must pay the full amount within 30 days, unless payment arrangements have been discussed prior to service. If this payment is not received within the 30 days, the amount will be assessed an interest payment of 3% each 30 days thereafter. If the account is not completely paid in 90 days, the account will be referred to our collection agency and an additional 50% charge will be applied to cover the collection fee. Filing of insurance claims is a courtesy that we extend to our patients. All charges are your responsibility from the date the services are rendered. If payment problems arise, we encourage you to contact us promptly for assistance in the management of your account. Please contact our business manager if you have any questions about your account.

PATIENT NAME _____ DATE _____

PATIENT SIGNATURE_____