The Center for
RHEUMATOLOGY LLP
Diagnosis, Care and Research

MRN: ____________

Payment Policies

Thank you for choosing us as your rheumatological care provider. We are committed to providing you with quality and affordable health care. We have developed the following updated payment policies, please read them, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans, including Medicare. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If your Insurance requires a referral for an office visit and we do not have a referral on file, you will be responsible for any amount that was not paid by your insurance company. *Please help us expedite this process. If you are aware that your insurance requires a referral, please try to provide one before the time of your appointment or have one ready at the time of your appointment.*

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage

*If you **DO NOT** have insurance there is a $175.00 deposit for your office visit. If your visit or any services associated with your visit exceeds $175.00, you will be billed for the remaining amount due. *

1. ***Co-payment.*** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.
2. ***Non-covered services.*** Please be aware that some – and perhaps all – of the services you receive may be noncovered or considered not reasonable or necessary by Medicare or other insurers. You will be required to pay for these non-covered services in full.
3. ***Proof of insurance.*** We must obtain a copy of your driver's license as well as current valid insurance and prescription cards to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Albany:
4 Tower Place, 8th Floor | Albany, NY 12203
Phone: (518) 489-4471 | Fax: (518) 489-4506

Saratoga:
6 Care Lane, Suite 101 | Saratoga, NY 12866
Phone: (518) 584-4953 | Fax: (518) 584-7916

The Center for
RHEUMATOLOGY LLP
Diagnosis, Care and Research

MRN: _____________

4. ***Claims submission.*** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
5. ***Coverage changes.*** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
6. ***Nonpayment.*** If your account is over 90 days past due, you will be notified that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. TCFR can charge you for the collection agency fee to satisfy your debt and to maintain active status with the Practice. TCFR also reserves the right to discharge you from the Practice if your account is put into collections for non-compliance.
7. ***No Show Fee.*** The Center for Rheumatology has instituted a "No Show Fee" policy that will result in a $50 fee for a follow-up appointment and a $100 fee for a new patient appointment if you do not show up for your appointment or cancel within 24 hours.
8. ***Returned check fee:*** A $20 fee will be charged for checks returned due to insufficient funds.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name: ___________________________________ DOB (MM/DD/YYYY): ________________

____ ______________________

Signature of patient or responsible party **Date**

Albany:
4 Tower Place, 8th Floor | Albany, NY 12203
Phone: (518) 489-4471 | Fax: (518) 489-4506

Saratoga:
6 Care Lane, Suite 101 | Saratoga, NY 12866
Phone: (518) 584-4953 | Fax: (518) 584-7916