Rheumatology Care Associates
We Care

Financial and Office Policy

Thank you for choosing us as your Rheumatology care provider. We are committed to providing you with quality and professional care. We ask that you please read this financial and office policy carefully and ask if you have any questions about our fees, our policies or your responsibilities. This is to help keep you informed and avoid any potential misunderstandings.

Insurance:

As a courtesy to our patients, we will gladly file the claims necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If you are not insured by the plans we participate in, payment in full is expected at each visit. If you are insured by a plan we do business with, **but don't have an up-to-date insurance card on file**, payment in full for each visit is required if we can't verify your coverage. It is your responsibility to notify our office if any patient information changes (i.e., name, address, telephone, insurance information, etc.) and do so at each visit. **If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.**

Deductibles and Co-pays:

By law, all co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. To make payments convenient we accept visa, master card, American Express, money orders, cash and checks. The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Rheumatology Care Associates PLCC. Address: 2741 Citrus Tower Blvd, Clermont, FL-34711
Phone :352-717-0603 Fax: 352-717-0604
Website:*www.rheumatologycareassociates.com*
***Email**: info@rheumatologycareassociates.com*

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Late Fees:

I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

Appointments/Cancellations:

We gladly reserve appointment times for you and appreciate that you have chosen Rheumatology Care Associates PLLC, for your care. As a courtesy, we will remind you of your appointment by calling and/or text/emailing you prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. We reserve the right to charge $25 for regular appointments for canceled or broken without advance notice of 2 business days

Financial Dismissal: Patients who do not make payment arrangements risk being dismissed from the practice. Rheumatology Care Associates. PLLC reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

Credit Card on File Policy

At Rheumatology Care Associates PLCC, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Furthermore, an "outstanding balance" charge of 1.5% of the total bill will charge for each month that the bill remains unpaid. Your credit card information is kept

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confidential and secure and payment to your card are processed **only** after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I (we) undersigned, authorize and request Rheumatology Care Associates PLCC to charge my credit card for balances for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Rheumatology Care Associates PLCC. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 days notification to Rheumatology Care Associates PLCC writing and the account must be in good standing.

Please initial that you understand each of our office policies

___Late Arrival Policy:

Dr. Prakash wants all patients to have the opportunity to be seen for his/her entire scheduled visit time. Thus, she operates under a "therapist" model, meaning each appointment has a dedicated length of time. I understand that arriving late for my appointment may result in my visit being truncated to allow for others to be seen on time. I also understand that a shortened visit may result in an incomplete assessment, and I may need to return for further assessment

___Telephone and Email Policy:

I understand that I will often be asked to schedule an appointment if issues or questions arise between scheduled appointment times. I understand that the best way to discuss my care is in a scheduled office visit to allow for examination as necessary. I understand that there are inherent privacy concerns in communicating by email, and I will use the patient portal for any general, non-urgent questions. For more involved matters, I will schedule either an office visit or a telephone encounter.

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___Laboratory Results, Refill, Forms, and Paperwork Policy:

I agree to come to my follow-up appointments or schedule a telephone encounter so I can discuss the results of any of my laboratory results and what they mean to my care. I agree to request all refills at the time of my visit. I understand that if I cancel or reschedule an appointment, I may run out of my required medication. We only provide prescription refills during an office visit with a physician. We require office visits on a regular basis for all patients taking prescription medications. Please bring all prescription bottles and a current detailed medication list with you to your appointment. I understand that requesting paperwork and form completion is best done during my appointment. I agree to pay the out-of-pocket fee of $50 for any letters, forms, or other paperwork that require completion by Dr. Prakash outside of scheduled appointment times. I understand that I can avoid this charge by scheduling an appointment and bringing the forms with me to the office visit.

___Hospital/Emergency Policy:

I understand that Dr. Prakash does not admit to the hospital. She may recommend I go to the Emergency Room if I am having symptoms of an emergent condition or need to be seen urgently, but my care will be under the hospital physicians. Though Dr. Prakash will make every best effort to communicate with my treating doctors, it is ultimately my responsibility to own my records and carry the names and contact information of my doctors to the ER.

___Controlled Medications/Marijuana Policy:

Dr. Prakash does not prescribe opiates or medical marijuana for the treatment of chronic pain, or benzodiazepines for the treatment of chronic anxiety or insomnia. She does not take over the prescribing of these medications from another physician. I understand that Dr. Prakash is required by law to review my prescription refill habits through the Prescription Monitoring Program, even if she is not prescribing me a controlled substance. I also understand that Dr.

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Prakash always communicates with prescribing physicians about my treatment plan if it is related, even if she is not also prescribing me controlled substances.

___Attorneys:

In the event Dr. Prakash is required to work with an attorney, or is required to appear in court, the current hourly rate, billed by the quarter hour, will be charged, based on the most recent Attorney Fee Schedule.

___Violence and Threats:

Any threats or aggressive or violent behavior directed toward staff, other patients, or neighboring businesses will result in dismissal from the practice.

___Updates:

We will update these policies from time to time. You may review the latest policies on request.

I have read and agree to the above financial, billing, and office policies.

Patient or Guardian's Name (print):_____
Signature: _____
Date: _____

Note: *The patient (or Guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud. Thank you for understanding our office policies. We are excited you chose Rheumatology Care Associates PLLC for your rheumatological care.*

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Notice of Privacy Practices

Notice of Privacy Practices Written Agreement:

I have read a copy of Rheumatology Care Associates PLLC 's Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Rheumatology Care Associates PLLC has a link to the Notice of Privacy Practices on the practice website located at *www.rheumatologycareassociates.com*

Patient or Guardian's Name (print):_____
Signature: _____
Date: _____

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