

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider. The content of this document may not be changed.

1. Each patient is responsible for his or her own bill.
2. Payment of all insurance co-payments and deductibles is required at the time medical services are rendered. A billing fee of \$15 will be charged if you are unable to pay required co-payments on the day of service.
3. If your insurance company requires a referral, it is your responsibility to have a current, valid referral for all services provided by RMAAI.
4. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks and major credit cards, and Care Credit.
5. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
6. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay. If your insurance company has not paid your full account within 90 days, you must pay the outstanding balance without further delay. All accounts must be current at the time of an office visit.
7. We require that you set-up to have any remaining balances on your automatically charged to your credit or debit card on the 25th of each month. If you chose instead to receive a statement for remaining balances, a **\$25.00** processing fee will be applied to your account.
8. An account is considered past due 30 days following billing. There is a **\$25.00** late fee applied to your account if we do not receive full payment within 30 days. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency and/or attorney. By signing below, you agree to pay collection costs up to 40% with or without suit and/or reasonable attorney's fees on any delinquent balance, if referred to any agency or attorney for collection or suit. .
9. Patients will be held liable for any damage done to the office.
10. A \$60.00 fee will be charged on all returned checks.
11. Patients who fail to appear for their scheduled appointments may be charged a fee of \$100.00, unless the patient cancels the appointment at least 24 hours before the scheduled appointment time.

USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

AUTHORIZATION TO PAY BENEFITS

I further authorize and direct said agency, attorney or Insurance Company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

Signature of Patient or Responsible Party

Date