Arizona Arthritis & Rheumatology Associates, P.C.

General Phone (480) 443-8400
Fax (480) 443-8697

Patient Financial Responsibility

PATIENT INFORMATION

PATIENT NAME Last	First	M.I.	**SOCIAL SECURITY NUMBER**
ADDRESS Street			**DATE OF BIRTH** / **SEX** ☐ Female ☐ Male
City / State / Zip / **HOME PHONE NO.**			**MARITAL STATUS** ☐ Single ☐ Divorced ☐ Married ☐ Widowed
EMPLOYER			**EMPLOYER PHONE NO.**
EMPLOYER ADDRESS			**PATIENT OCCUPATION**
INSURANCE COMPANY	**ID #**		**GROUP #**
SECONDARY INSURANCE COMPANY	**ID #**		**GROUP #**

PERSON RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.
If patient is a child please indicate if parents are: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

NAME			**SOCIAL SECURITY NUMBER**
ADDRESS Street			**DATE OF BIRTH**
City	State	Zip	**HOME PHONE NO.**
EMPLOYER			**EMPLOYER PHONE NO.**
EMPLOYER ADDRESS			

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	**NAME OF REFERRING PHYSICIAN**

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY Name	**PHONE NO.**
ADDRESS	

I hereby authorize Arizona Arthritis & Rheumatology Associates, P.C. to release any information in the course of my examination and/or treatment as permitted by law to facilitate treatment, payment, or healthcare. I hereby authorize payment directly to Arizona Arthritis & Rheumatology Associates, P.C. for surgical and medical benefits, if any, otherwise payable to me under terms of my insurance. I hereby authorize photocopies of this to be as valid as the original.

I am financially responsible for all non-covered services, insurance denials and all services rendered without a referral, if my plan requires a referral for services rendered.

I hereby agree to immediately pay all statements received from Arizona Arthritis & Rheumatology Associates, P.C. for services rendered. I agree to pay interest on all past due accounts (over thirty days) at the rate of 1.5% per month/18% per annum, if it becomes necessary to put my account in the hands of a collection agency or attorney. I also agree to pay all such costs of collection and reasonable attorney's fees incurred.

Signature:_____ **Date:**_____

PLEASE COMPLETE THIS PATIENT INFORMATION AND AS MUCH OF THE ATTACHED MEDICAL HISTORY AS POSSIBLE BEFORE OFFICE VISIT.

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Financial Policy

Thank you for choosing Arizona Arthritis & Rheumatology Associates as your healthcare provider. We are committed to providing the highest quality of care to our patients. Your understanding of our Financial Policy and payment for services are important parts of this relationship.

INSURANCE: We will bill your insurance company for your medical visit and services; however, you should be familiar with your own insurance terms/ contract/coverage. Please be advised that it is your responsibility to verify what your insurance will cover and what it will not (copayments, deductibles, coinsurance, and other patient responsibility amounts). We cannot waive deductibles, coinsurances, or copays that your insurance requires. This is a violation of insurance rules. **Initial:**_____

To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, and any change of insurance information. You are responsible for promptly informing our office of any changes in patient information (i.e., address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the bill being categorized as a patient's responsibility. **Initial:**_____

We accept most major insurance plans. However, with the frequent changes in the insurance marketplace, it is a good idea for you to contact your insurance company before your appointment and verify if we are a participating provider as per your plan. If we are not a provider under your insurance plan, you will be responsible for payment in full at the time of service. As a courtesy, however, we will file your initial insurance claim, and if you have a copay assistance program we will attempt to bill it as a courtesy as well. If not paid within 45 days, you will be responsible for the total bill. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you. **Initial:**_____

REFERRAL/PRIOR AUTHORIZATION REQUIREMENTS: It is your responsibility if your insurance requires you to obtain a referral from your Primary Care Physician (PCP) for all specialty services. If a referral is not in place for your visit you will be responsible for the costs associated with the services provided. Our patients may require Prior Authorizations for injections, infusions, and medications. Patients must inform AARA if and when they have changes or additions to their insurance coverage so that we can update any existing Prior Authorizations and properly bill for services. You acknowledge receipt of our financial policy and will be held financially responsible for any services your insurance company denies. **Initial:**_____

PATIENT RESPONSIBILITY: All copayments, deductibles, patient responsibility amounts, and past-due balances are due at check-in unless previous arrangements have been made with our business office. Although we may estimate what your insurance plan may pay, the insurance plan makes the final determination of your eligibility and benefits. **Initial:**_____

COLLECTIONS/CC ON FILE (CCOF): **Please see the full CCOF agreement on our website under "patient forms" and sign our consent form. We require an active credit card on file for all patients. Your CCOF will be charged for any remaining balance determined by your insurance carrier to be "patient responsibility" and will be automatically charged if you fail to pay your bill within 30 days. We will automatically charge your card after day 30 if we do not receive payment. Late cancel/no-show fees will be charged immediately (see below). Payment is due at the time services are rendered. If your account is transferred to an outside collection agency, you assume all costs of collection, including but not limited to agency collection fees, court costs, interest, and legal fees. You will not be able to be seen as a patient until your collection status is resolved. **Initial:**_____

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CANCELLATIONS/ NO SHOWS: **Please see the full Cancellation policy on our website under "patient forms." Due to Arizona's high demand for Rheumatologists, we have a zero-tolerance policy for New Patient no-shows. New Patients who no show will not be permitted to reschedule. Missing an appointment also means another patient cannot be seen at the appointment time. If you are an established patient and unable to keep your appointment, we kindly request 24 business hours' notice to cancel or reschedule your appointment. If, for any reason, you fail to cancel/reschedule with at least 24 hours' notice, you will be charged $75.00 **Initial:**_____

PATHOLOGY/LAB SERVICES: You may receive an additional bill from the lab service provider based on your clinical needs during your appointment. All questions about these fees must be directed to the lab service provider. **Initial:**_____

NON-COVERED SERVICES: You must understand whether or not any services will be covered. The patient or the patient's legal representative is ultimately responsible for all charges for services rendered. "Non-covered" means a service will not be paid for under your insurance plan. If non-covered services are provided, you will be expected to pay for these services at the time they are provided or when you receive a statement or explanation of benefits (EOB) from your insurance provider denying payment. **Initial:**_____

COMPLETING FORMS: We do not fill out disability forms of any kind; however, our records may be requested as supporting documentation to assist another provider with this paperwork. **Initial:**_____

I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by Arizona Arthritis & Rheumatology Associates to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate Arizona Arthritis & Rheumatology Associates to extend credit to me for services provided.

Please sign and date, acknowledging that the above policies have been read and understood. Please see the front desk if you have questions about any of these policies.

Patient Name Printed:_____ **Date of Birth:**_____

Patient Signature:_____ **Date:**_____

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Credit Card on File Agreement

Arizona Arthritis & Rheumatology Associates has implemented a new credit card policy. We kindly request our patients' guardian/guarantor for a credit card, which may be used later to pay any balance due on your bill. Copays are still due at the time of service.

The information will be held securely until your insurance plan has paid its portion of the claim and notified us of any additional amount you owe. We will send you a statement of your outstanding balance at that time. If your outstanding balance is not paid within 30 days, we will be charging the balance to your credit card on file. You may call our office if you have a question about your balance. This "Credit Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal, and our Business Office can answer any questions about the balance due. If you have any questions about the card-on-file payment method, please do not hesitate to let us know.

By signing below, I authorize Arizona Arthritis & Rheumatology Associates to keep my signature and credit card information securely on file in my account and charge my credit card for any outstanding balances when due.

Patient Name:_____**Date of Birth:**

Patient Signature:_____**Date:**

Credit Card Holder Name Printed:

Credit Card Holder Signature:_____**Date:**

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Frequently Asked Questions

Frequently Asked Questions Regarding the Credit Card On File Agreement

How much and when will money be taken from my account?

The insurance companies, on average, take approximately two weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. It simply depends on your policy and what you may owe. Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed with the credit card on file.

How do you safeguard the credit information you keep on file?

We use the same methods to guard your credit card information as we do for your medical information. The credit card processing component of our HIPAA compliant practice management system securely protects the card information. This system stores the card information for future transactions using the same technology as any online retailer. We cannot see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.

What are the benefits?

It saves you time and eliminates the need to write checks, buy stamps, or worry about delays in the mail. It also allows us the chance to refund patients easily, if necessary. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than us storing the information. The extra time the staff has can now be spent directly helping the patients via phone, with insurance claims, or in person.

I always pay my bills on time. Why do I have to do this?

The entire billing process is time-consuming and wasteful, and the few patients we send to the collection agency cost a lot of money. Reducing unnecessary costs is essential for us to continue to be allowed as an in-network provider with most insurance companies. Nothing is changing about how much you end up paying.

What if there is a payment discrepancy, or I have other payment questions?

Please contact our Business Office at (480) 443-8400. This policy does not compromise your ability to dispute a charge or question your insurance company's explanation of benefits.

Will I still receive a paper bill by mail?

Yes. You will receive one bill showing what will be charged to your card in 30 days. If you prefer to pay by an alternative method, you may do so during that period. If you do not wish to make any payment method changes, hold onto the statement for your records, and your card will be charged.