NORTHERN CALIFORNIA ARTHRITIS CENTER

OFFICE POLICY FOR SERVICES

January 2019

- **Insurance Cards: Due to the many ongoing changes in insurances, we require that you bring your insurance card(s) to your office visit in order to bill your insurance. If you do not have your insurance card at the time of your visit we will require payment at the time of service.**
- **Medical Records Request: Ten working days from the date of the signed authorization. Incomplete request will be returned. See Medical Records for authorization form.**
- **Disability, DMV, SDI and Social Security Forms: Allow 48 hours for any disability forms, DMV placards, SDI and Social Security or Short-term disability forms.**
- **Prescriptions: Contact your pharmacy for refills. Allow 48 hours per refill. Do not run out of medication.**
- **Fees:**

  Medical Records: $35.00 flat fee
  (Fees are waived if your records are requested in writing from another physician's office)

DMV, PG & E, Jury Duty forms:	**$30.00**
SDI and Social Security forms, FMLA:	**$85.00**
Long/complicated forms of any kind:	**$100.00-175.00**
Returned Check Charge:	**$25.00**

As a courtesy to the other patients, we will file claims with your insurance. It is your responsibility to remit payment for charges not covered by your carrier, and to ensure your carrier remits payment for your covered charges. Verifying eligibility and/or benefits is not a guarantee of payment from your insurance. Ultimately your insurance coverage is an agreement between you, your insurance carrier and/or your employer.

Once the claim has been processed by your insurance, you will receive our statement and are responsible for the balance. Patients payment are due and payable within thirty days of the statement date. If your payment is late, or if you have note made financial arrangements, we well mail a reminder notice indicating a problem with your account. An additional charge of $10.00 may be added to cover the cost of the added service.

If you are experiencing financial circumstances beyond your control, please call our billing department to make payment arrangements. We will make every effort to assist you in managing your account. We hope to avoid any disagreement over payment for professional services by clearly defining our policies. If you have any questions concerning this policy or need any assistance with your account in the future, please contact us immediately.

PRINT NAME:_____DOB: _____

Patient Signature:_____Date:_____