San Antonio Arthritis Care Centers

Jeffrey A. Feinstein, M.D.   Kenneth F. DesRosier, M.D.
www.arthritis-sa.com
210.590.9596 • Fax 210.693.1491

Patient Financial Policy

Thank you for choosing San Antonio Arthritis Care Centers as your health care provider. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with patient account representative. **We accept cash, check, VISA, American Express, MasterCard or Discover**. Absolutely no post-dated checks will be accepted. A service fee of $50 will be charged to your account for all returned checks.

Insurance Claims

There is no doubt that health insurance benefits are confusing. **Most plans do not provide 100% coverage for medical bills**. Each plan has its own set of rules, exclusions and benefit structures. **It is your responsibility to be familiar with your insurance policy's requirements.** If you are unsure of your coverage as it relates to services rendered at our office, you should call the customer service telephone number on your insurance card before receiving those services. Insurance is a contract between you and your insurance company. **We will bill your insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information. Incomplete insurance information may result in patient responsibility for the entire bill.** Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. We collect all fees before and at the time of the appointment.

Participating Insurances

We accept most insurance plans for our patients. Please call our insurance verification department for more information. It is your responsibility to given all new insurance information to our staff before your appointment.

Referrals

If you have an HMO or POS plan with which we participate, you may need a referral from your Primary Care Physician (PCP) to see our Specialist. Check your insurance card or call your insurance carrier to determine if your plan requires you to have a referral to see a Specialist. We must have the referral in the office before you are seen by our Specialist. You will be asked to reschedule your appointment in the event that your referral is not here at the time of your appointment. For this reason, it is important that you make sure that your Primary Care Physician has sent the referral and that we have received it before you come in to the office. Another option is to bring the referral with you at the time of your appointment, but this must be coordinated in advance with our referral coordinator.

Self-pay Patients

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay new patients will be required to bring a flat fee of $500 at the initial appointment. Only cash or credit card will be accepted. For all subsequent visits, payment is due in full at time of service. Patients paying with check or credit card will be required to pay for services rendered in full. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Missed Appointments

San Antonio Arthritis Care Centers requires 48-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a "No Show" fee of $50 to established patients or $100 fee to New patients. Any infusion center appointments missed and not canceled may be charged a "No Show" fee of $100.

Returned Checks
San Antonio Arthritis Care Centers will charge a service fee of $50 for a returned check which is payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. You will be placed on a cash or credit only basis following any returned check.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent 3 statements. If payment is not made on this account, a notice of collections will be sent asking you to contact our business office to pay your account in full or make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

Payment plans are available for account balances in excess of $50 in the event of a financial hardship. Payment terms are as follows: 50% of the total balance must be paid at inception of the payment plan agreement. The remaining balance will be due within 2 months. A bill will be sent to your mailing address each month for the amount agreed upon. If you are delinquent on a payment, your account may be turned over to the collection agency. All charges incurred after the inception of the payment plan will be due with 30 days of receipt of the statement. Failure to comply with these payment terms may result in a dismissal from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact our Business Office Monday through Thursday, 8:30 am to 5:00 pm. Please call 210.590.9596.

Authorization to Release Information:
I authorize San Antonio Arthritis Care Centers to release information to my healthcare insurer or the Center for Medicare and Medicaid Services (CMS), or any other entity necessary to determine benefits and process claims related to medical services that have been provided to me. An electronic copy of this authorization will be deemed as valid as the original. I allow a photocopy of my signature to be used to process insurance claims.
Assignment of Benefits:
I authorize payment of insurance benefits, including CMS benefits, for medical services provided to me directly to San Antonio Arthritis Care Centers an electronic copy of this authorization will be deemed as valid as the original. I understand that I am responsible for any amount not covered by my insurance.
Financial Responsibility:
I have read the San Antonio Arthritis Care Centers Financial Policy and understand that I am responsible for all fees for medical services rendered to me by the physicians and staff of San Antonio Arthritis Care Centers. Any fees deemed patient responsibility or are not covered by my insurance company will be **due** on the **day of service** or upon resolution of my insurance claim**. San Antonio Arthritis Care Centers reserves the right to request payment of these fees before my insurance company has completed the processing of my claim (s) or if my claims are denied.** It is my responsibility to notify San Antonio Arthritis Care Centers of any changes in my health care coverage before services are rendered. I understand that by signing this form that I am accepting financial responsibility as explained above for payment for medical services rendered to me. An electronic copy of this authorization will be deemed as valid as the original. A photocopy of this agreement is to be considered as valid as the original.

Patient Signature:____Date:__________________

Please print your name:____