SUN VALLEY ARTHRITIS CENTER
OFFICE POLICY

PLEASE READ EACH PARAGRAPH BELOW AND INITIAL THAT YOU UNDERSTAND EACH PARAGRAPH

I will inform Sun Valley Arthritis Center, Ltd of any changes in my insurance coverage.	__________ Initials
I understand the billing process may take 4-6 weeks at which time my insurance will determine and pay for services per my contract.	__________ Initials
I understand that if my insurance requires an authorized referral for care at our practice, that it will secure this referral from my primary care physician/provider prior to my arrival at the office. My visit cannot begin until a referral is received	__________ Initials
I understand that it is my responsibility to pay all co-pays, deductibles, and estimated co-insurance amounts at the time service is rendered and any remaining balance as determined by my insurance company.	__________ Initials
I understand that Sun Valley Arthritis Center, Ltd may request proof of my insurance premium payment.	__________ Initials
I understand that if I fail to cancel without giving 24 hours notice or don't show up for a scheduled appointment on time I will be subject to a **$40.00 No Show/Late fee.** No shows for new patient appointments and report visits may be subject to a **$55.00 cancellation fee.** Exceptions for emergencies will be considered on an individual basis.	__________ Initials
I understand that all delinquent/past due accounts are subject to collection. In addition to the balance due, I will be responsible for the payment of all fees, including, but not limited to, collection, attorney and court fees. Checks returned for insufficient funds or closed account will be charged **an additional $50.00 fee** in addition to the amount of the check. Reimbursement must be made within 10 days of notification. If you have a check returned, we will no longer accept checks from you as a form of payment. Cash, Debit Card, or Credit Cards will be the only accepted forms of payment.	__________ Initials
I understand that I will alternate seeing Dr. Joy Schechtman and a Nurse Practitioner (NP) for all follow up office visits.	__________ Initials

With my signature:

1. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.
2. I request that payment of authorized benefits be made on my behalf. I assign the benefits to which I am entitled (including Medicare, private insurance and any other health plans) be made payable to Sun Valley Arthritis Center, Ltd.
3. I affirm, this assignment will remain in effect until revoked by me, in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance.
4. I affirm that I have read, and fully understand, the policies set forth on this document.
5. I affirm that the information I have provided on this form is accurate and true to the best of my knowledge.

______________________________	______________________
Patient Signature:	Date:

______________________________	______________________
Signature of Parent/Guardian for Patient under the age of 18	Date:

Sun Valley Arthritis Center participates in a variety of medical research studies. Would you like more information about participating in our studies?

Yes: ☐

No: ☐