AUTHORIZATION AND FINANCIAL POLICY

Rheumatology Associates of North Alabama is committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- ***Our office participates with a variety of insurance plans. It is your responsibility to*** :

**** Bring your insurance card/cards and drivers license.
**** Be prepared to pay your specialist co-pay, deductible and /or Out of Pocket up to $400.00. Payment can be made by check, cash or credit card (MasterCard, Visa or Discover).
**** For medical care not covered under your insurance, payment is due at time of service.
**** If your account is placed with a Collection Agency, you will be charged a fee of 25% of the balance.

- Our office is not contracted with Medicaid of Tennessee or Medicaid of Mississippi and BCBS of Mississippi. We file all insurances as a courtesy.
- If you are unable to pay for necessary medical care you may be eligible for financial assistance. All non insured patients will be asked to pay $400.00 at the first visit. Our office will work with you to arrange payment plans and/or financial assistance after the first visit.
- Referrals: It is YOUR responsibility to bring any required referrals for treatment, at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you will be financially responsible for your visit and all charges associated with your visit.
- If the patient is a minor (under 18 years of age), the parent or guardian must sign below. The patient or guardian or unaccompanied minor is responsible for any payment due at time of service and must bring the necessary referrals and insurance card/cards.
- If you have questions about your insurance we are happy to help you. Specific coverage issues should be directed to your insurance company member service department (the number is usually on the back of the insurance card).

CONSENT FOR MEDICAL TREATMENT

I hereby consent to and authorize RANA personnel to render usual customary medical treatment to me. I understand the treatment provided will be in accordance with the standard of care at the time the care is provided, including but not limited to office visits, injections, infusions and interpretations of x-rays and laboratory.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to our billing department. Please sign that you have read and agree to the financial policy and Consent for Medical Treatment.

________________________________ ____________________
Signature of Patient or Responsible Party Date

________________________________ ____________________
Signature of Co-Responsible Party Date