

Arthritis & Rheumatology Associates of South Jersey Financial Policy

Your complete understanding of your financial responsibilities is essential. Your insurance is a contract between you, your employer and the insurance company. **We are not part of that contract.**

Appointment Cancellations: Please notify our office of any appointment cancellations at least 24 hours in advance by calling the office or the answering service. We reserve the right to charge you (not your insurance company) for a missed appointment. This is a \$35.00 fee (subject to change without prior notice).

Laboratory, Radiology and other diagnostic service bills: Please check with your insurance company to verify what your insurance benefits allow for. The doctor may order these during your visit. These services are billed separately by the laboratory or diagnostic facility that performs these tests and are not covered by payments that you make to us.

Medical Record Fees: There will be a fee for copying medical records, \$1.00/page up to \$100.00. There also will be an additional fee for postage & search fee of \$10.00. You must fill out a medical records request form to obtain a copy of your medical records. Please allow up to 30 days for copying of medical records.

Payment Responsibility: I hereby authorize payment directly to **Arthritis & Rheumatology Associates of South Jersey, P.C.** of the physician's attendance benefits otherwise payable to me but not to exceed the charges as stated. I understand that I am financially responsible to **Arthritis & Rheumatology Associates of South Jersey, P.C.** for the charges not covered by this authorization. I also understand and agree that if my account is delinquent and incurs collections fees or legal fees, I am responsible for payment of those fees as well as the full balance of my account.

I have read and fully understand the financial policy set forth by Arthritis & Rheumatology Associates of South Jersey. I understand and agree to the terms of this policy. I also understand and agree that the terms of this financial policy may be amended by Arthritis & Rheumatology Associates of South Jersey at any time without prior notification to me.

Signature of patient or responsible party

Date

Printed name of patient or responsible party

Date

Witness

Date

Arthritis & Rheumatology Associates of South Jersey
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