**RHEUMATOLOGY ASSOCIATES, P.C.**

**FINANCIAL AGREEMENT**

This agreement made and entered into to be effective as of the date recorded below between Rheumatology Associates, P.C. and Patient, or Responsible Party if not the Patient, herein referred to as Patient, named below. **By executing this agreement, Patient agrees to pay for all services provided by Rheumatology Associates, P.C.**

**Monthly Statement**: If Patient has a balance on his/her account, he will receive a monthly statement. The statement will show any previous balance due, any new charges to Patient’s account, and any payments or credits applied during the month.

**Payments**: Unless Rheumatology Associates, P.C. approves other arrangements, the Patient’s balance is due when the statement is issued and is considered past due within 30 days of the statement date.

**Past Due Accounts**: Rheumatology Associates, P.C. will take all of the necessary steps allowed by law to collect on past due accounts. If Rheumatology Associates, P.C. is forced to refer the account to an outside collection agency, a service charge, which will be 30% of the balance, will be added to the account. Patient agrees to be responsible for fees allowed pursuant to chapter 537.7103 of the Iowa code.

**Returned Checks**: Rheumatology Associates, P.C. will charge a fee in the amount of $30 for each check returned by the Patient’s bank.

**Transferring / Receiving of Records**: Patient will need to make a written request to have copies of their records sent to another doctor or organization. This includes all relevant information concerning patient, including payment history. If Patient requests that records be sent to Rheumatology Associates, P.C. from another doctor, Patient authorizes Rheumatology Associates, P.C. to receive all relevant information concerning patient, including payment history.

**Insurance**: Insurance coverage is a contract between Patient and the insurance carrier. Any co-payment required by an insurance company must be paid at the time of service. Every patient is responsible for knowing the specific requirements of their insurance companies. Rheumatology Associates, P.C. will bill Patient’s primary insurance carrier as a courtesy, however it is the insurance carrier that makes the final determination of eligibility and payment. To assist you with all insurance requirements, please let us know if you are required to have a referral, prior authorization or the required use of a particular hospital or lab. It is the Patient’s responsibility to make sure all insurance requirements are fulfilled. It is also the Patient’s responsibility to notify Rheumatology Associates, P.C. of any changes in their insurance coverage.

By signing this agreement, Patient agrees to all of the terms and conditions contained herein and the agreement will be in full force and effect. I authorize the use of my signature on all insurance submissions. Rheumatology Associates, P.C. may use my health care information and may disclose such information to my insurance carrier and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

Signature/Date

(Responsible Party): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party

(If not the patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *July 2012*