

Carolina Arthritis Center

2355 Hemby Lane
Greenville, NC 27834

Ph# 252-321-8474

800-879-8304

Fax# 252-317-2898

FINANCIAL POLICY

We are doing everything possible to hold down the cost of your medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENTS AND BALANCES ARE EXPECTED AT THE TIME OF SERVICE.

Payment is required at the time services are rendered. This includes applicable coinsurances and deductibles. Co-payments are required to be paid at the time of service. Patients will not be allowed to be seen with delinquencies of 1 or more co-pays. Carolina Arthritis Center accepts cash, personal checks (in-state only), VISA and MasterCard. There is a service charge for returned checks in the amount of \$25.00.

After we receive the explanation of payment from your insurance company, you are responsible for any balance not covered by the insurance company. Balances not paid within 60 days may be turned over to a collection agency and you will be dismissed from the practice. Please call our Billing Office, Monday through Friday at 252-321-8474 with any questions.

If you have MEDICARE only as your insurance, you will be responsible for your 20% at check-out, each visit.

Infusion co-insurance must be paid at the time services are rendered. Infusion co-insurance amounts are only estimates and you are ultimately responsible for any additional amounts.

Missed appointments represent a cost to us, to you, and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments in the amount of \$100.00. Two missed scheduled appointments may result in dismissal from the practice.

It is your responsibility to notify Carolina Arthritis Center of any changes in your insurance coverage prior to your scheduled appointment. Failure to do so may result in your appointment being cancelled when you arrive.

I have read and understand the Carolina Arthritis Center Financial Policy. I agree to assign insurance benefits to Carolina Arthritis Center whenever necessary.

Signature of insured or authorized representative

Date

Signature of witness from Carolina Arthritis Center

Date