Dynamic Arthritis Care Clinic, PLLC
Carlos E. Ramirez, M.D.
Board Certified internal medicine & rheumatology

POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

Prior to seeing a medical professional at DACC, a staff member will discuss with you the likely costs involved in your procedure(s) and review your financial responsibility.

We accept certain insurance plans; therefore, please provide us with your insurance card. We will let you know if your plan is one for which we are a designated provider. If you wish to be seen at DACC, you are responsible for payment of all co-pays and or deductible charges at the time of service. If your insurance is a plan for which we are not a designated provider, we are more than willing to provide care and you will be responsible for payment at the time of service.

Please remember that insurance policies may not cover all conditions and fees. To be fully aware of your schedule of benefits, please read your insurance policy or talk with an insurance representative.

Although all services will be filed with your insurance, it is your responsibility to obtain a referral if one is required by your insurance to see a specialist. If your insurance denies de claim because a referral was not present at the time of the appointment, you will be responsible for the bill.

Any laboratory analysis that we require. but do not perform in-house will be sent to an external laboratory as required by your insurance. You may receive a separate bill for laboratory services.

We accept Medicare and will file all claims for patients with Medicare. Please give us your secondary insurance card and we will also file it.

We accept payment in the form of cash, credit or debit card.

If you are not going to be able to attend a scheduled appointment. 24 hours' notice is requested. We reserve the right to charge **$30.00 for no shows** or lack of notification of the intend to cancel the appointment in the aforementioned time frame.

We reserve the right to charge for copying of medical records or forms presented to the office for completion. All fees are available for review with our Office Manager.

I have read this financial policy and understand that **I** have financial responsibility for payment of medical services provided by DACC, and hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account. **I** agree to pay the legal expenses incurred by this office.

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Signature of Patient/ Responsible Party Date