Samy Metyas MD, Inc
Covina Arthritis Clinic.
500 W San Bernardino Rd, Suite A. Covina, Ca 91722 Tel 626-966-1909

Financial Policy Agreement

We are dedicated to providing the best care at the most affordable cost to you. Thus, we want you to completely understand our financial policies and your responsibilities.

Insurance and Patient Responsibilities

PAYMENT for healthcare services is required at the time of your visit. Payment includes any unmet deductibles, co-payment, co-insurance amount or non-covered charges from your insurance company. We accept cash, check, credit/debit cards.
Returned Checks will incur **an additional $25 charge.** You will be asked to bring cash/ money order/ certified funds to cover the amount of the check, plus the service charge to pay the balance prior to next visit. Advance cash payment for future visits may be required.

CO-PAYMENTS and DEDUCTABLES must be paid at the time of service. This arrangement is part of your contract with your insurance company, and cannot be waived. Failure on our part to collect co-payments and deductibles from patient can be considered fraud.

INSURANCE: If our office participates with your insurance plan, we will file your insurance claim for you. Due to many insurance products out there, our staff cannot guarantee your eligibility and coverage. If we cannot determine your coverage at the time of service, payment in full for that visit is required until we can verify your coverage. If your insurance plan does not pay your claim in 45 days, the balance will automatically be billed to you.

Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered", you will be responsible for the entire charge. Your signature below constitutes agreement to pay for such services.

Some services will need "prior authorization" from your insurance company, and if your insurance company denies the authorization request, and you still request services, YOU will be totally responsible for the charges. Medicare patients will be required to sign an "Advance Beneficiary Notice" (ABN).

If our office does NOT participate with your insurance company, we will file a claim for you; however, **YOU will be totally responsible for payment,** which is due at the time of service. You are responsible for paying us for the services provided because your insurance plan will be sending the payment directly to you.

STATEMENTS: All balances are expected to be paid in full upon receipt of a statement from our practice. Payments not received within 10 days are considered past due and could be subject to late fees or interest penalties.

OUT STANDING BALANCE or NON-PAYMENT: All past due accounts will be sent two statements. If payment is still not made after these two statements, a courtesy phone call will be made to try to make payment arrangements. If no resolution can be made within 90 days of the initial statement sent date, the account **will be sent to a collection agency, jeopardizing your credit score, and you may be discharged from this practice.** If this is to occur, you will be notified by *certified mail* that you have 30 days to find alternative medical care. Please note: during that 30-day period, our office will only be able to treat you on an emergency basis. **COLLECTION FEES**: In the event your account is placed in collection status, any additional fees incurred due to this, will be added to your outstanding balance.

This includes but not limited to late fees, collection agency fees, court costs, interest and fines. You understand that these additional fees will be your personal responsibility to pay in full.

WORKERS COMPENSATION: We DO NOT provide treatment for work-related illness/injury. If you do not disclose your visit is job related or you have a current or active workers comp claim, your claims will be denied by your insurance plan, AND you are financially responsible for all charges incurred for your visit.

COVERAGE CHANGES: If your insurance changes, please notify us promptly so we can verify to help you receive your maximum benefits. If you fail to notify our office of your insurance coverage change, the services provided by our office may NOT be covered and YOU will be responsible for paying our office.

OTHER SERVICES

FORM FEES: completing insurance forms, copying medical records, etc. requires staff time and time away from patient care. Therefore, we require Pre-Payment for completing forms, copying records, or extra written communication by this office. The charge is determined by the complexity of the form.

LATE CANCELLATION or MISSED APPOINTMENTS: Arriving promptly for your appointment is not only a courtesy but a consideration to those appointments are scheduled after yours. If you are running late, we appreciate your advance notification. If you do not cancel your appointment **at least 24 business hours before** or if you "no show", we will assess a $25 missed or no-show fee ($75 for a New Patient no-show fee and $50 for infusion no-show). This fee is not covered by your insurance plan and is your responsibility. **EXCESSIVE RE-SCHEDULING** will result in appointment restrictions or a fee to book/re-schedule. The office will give you ONE automated reminder call (or Text) of your upcoming appointments at least 2 business days in advance. If we are unable to reach you, you will still be liable for this charge if you canceled, rescheduled, or no-showed without 24-hours advance notice. **Please make sure your phone number is always updated in our system**.

REFERRALS: As a specialist, some health plan requires your Primary Care Provider (PCP) sends our office a Referral for you to be seen. If our office does not have a valid referral form from your PCP, your health plan will deny the payment. If this office recommends that you see another specialist, please check with your PCP to see which specialist you should see.

PRESCRIPTION REFILLS: Refills will be handled between Mondays-Thursdays from 8:30AM-4:00PM. Fridays between 8:30AM-3:00 PM. Any refills received after the above time frame will be handled the next business day. Please ask your pharmacy to put your prescriptions on "automatic refill" status and they will contact our office when you need refills. *Note: All narcotics refills requires an office visit, we do not mail prescriptions to patients.*

By signing below, I have read and understand the practice's financial policy and I agree to be bound by these terms. I also understand and agree that such terms may be amended by the practice from time to time.

*I also consent **Samy Metyas MD, Inc**. to use and disclose health information about me to carry out treatment, payment, and healthcare operations. (The Privacy Notice describes such uses and disclosures in detail). If I do not sign this consent, or later revoke it, **Samy Metyas MD, Inc .** May decline to provide treatment to me*

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Signature of Patient (Full Name) (or responsible party if minor) Date