Lomibao
RHEUMATOLOGY & WELLNESS CARE

Patient/Guarantor Responsibilities, Insurance Disclaimer & Private Pay Policies

I (name of patient/guarantor) _____ understand that if my insurance does not pay for my office visit or any other services performed for any reason, I remain fully responsible to pay for all services provided. It is the patient/guarantor's responsibility to understand how their insurance coverage works.

Initial here:

_____ It is the patient/guarantor's responsibility to determine if the provider/practice is IN or OUT of network with the patient's insurance by calling their insurance company. Patient/guarantor is **still responsible to pay for all services rendered** even if discovered non-covered/out of network after services rendered.

_____ It is the patient/guarantor's responsibility to update our office every time their insurance coverage changes, lapses, or terminates, prior to any services rendered. Patient/guarantor is **still responsible to pay for all services rendered** even if discovered non-covered/out of network due to change/lapse in insurance coverage, after services rendered.

_____ It is the patient/guarantor's responsibility to **come prepared to pay in full** for services rendered **on the day of the appointment at the time of service.** There is a **$30 declined transaction/returned check fee** for every declined transaction/returned check.

_____ The patient/guarantor understands that failure to provide **TWENTY-FOUR (24) BUSINESS HOURS** advanced notice of cancellation/rescheduling by phone, will result in an **automatic No Show Fee of ONE HUNDRED DOLLARS ($100) for NEW Patient** and **FIFTY DOLLARS ($50) for ESTABLISHED Patient** charged to the card on file. No Show Fees are not reimbursable by insurance and subject to change without notice.

No Show fees will NOT be refunded for any reason, as this is a non-recoverable loss of appointment time that would have been offered to another patient.

_____ It is the patient/guarantor's responsibility to determine if their insurance **requires referral from their PCP**, and ensure it is received by our office, prior to every visit. Patient/guarantor understands that they will be **subject to No Show Fee** if appointment is cancelled with less twenty-four (24) business hours advanced notice due to failure to ensure our office has their PCP's referral.

_____ If the patient/guarantor **No Shows or Cancels less than twenty-four (24) business hours (as described above) 2 (two) times**, (consecutive or non-consecutive appointments), as a pre-requisite before scheduling a third (3rd) time and every subsequent appointment, they will be **required to pay a Security Deposit in the amount equivalent to our current Private Pay rate.**

1. If the patient/guarantor No Shows or Cancels less than twenty-four (24) business hours on that 3rd appointment or any subsequent appointment, the patient/guarantor **forfeits the entire Security Deposit.**
2. If the patient/guarantor shows up on that 3rd appointment, then the **Security Deposit will be applied as a credit** toward that visit. This policy is subject to change on a case-by-base basis by management if consistent, reliable behavior is exhibited.

_____ The patient/guarantor understands that the practice does not offer payment plans as payment in full is due at the time of service, and **unpaid bills are reported to collection agency.** If the patient/guarantor's account is transferred to collections, **any and all fees assessed by the collection agency will be added to their balance**. Any patient with **unpaid bills forfeits any further services until all outstanding balances are paid in full**. Any patient sent to collections forfeits any future appointments. Those with unpaid bills or sent to collections also forfeit value-added services including but not limited to requesting refills, prescriptions, or other orders on the patient portal or telephone to all practice employees, until balance is paid in full.

_____ The patient/guarantor understands that private pay fees or any fees separate from insurance are **subject to change without notice.**

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to all of the above Patient/Guarantor Responsibilities, Insurance Disclaimer & Private Pay Policies of Lomibao Rheumatology & Wellness Care, PLLC.

_____ _____

Patient/Guarantor Signature **Date**

7700 Lakeview Pkwy Suite 300A
Rowlett, TX 75088
Phone: 469.825.4010
Fax: 469.825.4020