



## 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 ("my") responsibility to understand how my insurance coverage works.

Initial here:

\_\_\_\_\_ It is my 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 my responsibility to update the office every time my 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 my 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 my responsibility to determine if my insurance **requires referral from my 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 canceled with less twenty-four (24) business hours advanced notice due to failure to ensure our office has their PCP's referral.

\_\_\_\_\_ It is my responsibility to **complete all New Patient intake forms PRIOR to showing up** for appointment, or **arrive 30 minutes prior** to appointment time - **if intake forms incompletd, you may be subject to appointment rescheduling in order to accommodate our other patients.**

\_\_\_\_\_ 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 is hereby informed that we do not offer payment plans as payment in full is due at the time of service, and **unpaid bills are reported to collection agency**. If my 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