

## RODNEY BLUESTONE MEDICAL CORPORATION

RHEUMATOLOGY  
(ARTHRITIS AND RELATED DISORDERS)  
436 NORTH BEDFORD DR  
SUITE 303  
BEVERLY HILLS, CALIFORNIA 90210

### FINANCIAL POLICY AND HEALTH INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Balances carried to the next billing cycle will be subject to a service charge. We accept cash, checks, MasterCard, Visa, or American Express. We will be happy to help you process your insurance claim-form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

You are financially responsible for your co-payment, co-insurance, and deductible. Your co-payment, co-insurance, deductible, and past-due balances are due at the time of service. Contingent on your specific benefits, coverage, and services performed, additional money may be due at checkout. If you have a secondary insurance carrier, a portion of your co-insurance may be covered.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance at your request

**You must realize, however, that:**

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is **YOUR RESPONSIBILITY** to understand how your plan works before you seek treatment in our office.
2. We cannot know the details of YOUR INSURANCE PLAN. A simple phone call to your carrier will help you understand how your in and out of network coverage works. You should ask them: **A)** if you have a deductible? **B)** How much is your deductible? **C)** How much of your deductible has been met for the current year? **D)** What percentage are your co-insurance and/or co-payment? This will help you anticipate your responsibility.
3. If we are contracted with your plan we will bill you the amount your contract stipulates. We cannot take responsibility if your portion is "more than you thought it would be", "no one in your office told me that" or "I didn't know that wasn't covered by my insurance".
4. If we are not contracted with your plan you will be responsible for up to 100% of our fees.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. If we provide services to you that are not covered by your health plan, you will be responsible for full payment of those services. Your signature, below, constitutes agreement to pay for such services.

We must emphasize that, as healthcare providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you. We will gladly discuss your proposed treatment and answer any questions relating to your insurance at your request.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_