RHEUMATOLOGY ASSOSIATES
Of Greater Houston, PLLC

Rheumatology Associates of Greater Houston, PLLC
Dr. Maryam Khawari, M.D.
777 S Fry Road, Ste 102.Katy, Tx 77450
Phone:(281)-652-5943. Fax:(281)-652-5944
Email: info@rheumatologyassociateshouston.com

FINANCIAL POLICY

We are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibilities as our patient.

- It is your responsibility to contact our office to notify us of any changes to your information, such as a change in address, telephone number, or insurance information.
- You must complete and sign our Financial Policy before care is rendered.
- Payment is due at the time of services, including co-payments, deductibles, and co-insurances as applicable. If you are uninsured or if you are not insured by a plan, we do business with, payment in full is expected at the time of services. Insurance payment is an estimation, and the actual price will be verified once the claim is submitted to the insurance company, thus your responsibility may change.
- If you are insured, you must bring your insurance information and a photo ID to every appointment to ensure correct processing of all insurance claims. If you are insured by a plan, we work with but do not have your up-to-date insurance card, payment in full is required at the time of services if we cannot verify your coverage.
- It is your responsibility to understand your insurance policy and benefits.
- If applicable, you will be billed for both preventive and problem focused services when they are performed during the same appointment.
- We file insurance claims as a courtesy to our patients. Your insurance company may need you to provide certain information directly to the insurance company. You are responsible for complying with their request.
- **There is a 25 $ fee for all returned checks.**
- **If you do not show up for an appointment or cancel with less than 24 hours' notice, you will be charged a 25 $ rescheduling fee. You will need to pay the rescheduling fee of 25 $ before you can reschedule an appointment.**
- **Patients with 3 missed appointments may be terminated from the practice**.

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- We do our best to verify eligibility and determine patient responsibility prior to the appointment. If your insurance company denies payment because of benefit limitations or non-covered services, you will be responsible for the charges.
- If your insurance company needs any additional information, you are responsible for providing it to the insurance company.

I have read, understood, and been allowed to ask questions about this policy. I agree to comply with the policy as described.

Patient's name: _____

Signature: _____

Date: _____