Virginia Rheumatology Clinic

Brinda M. Dixit, M.D.
Diplomate of the American Board of Rheumatology
American College of Rheumatology
Assistant Professor of Medicine, EVMS

516 Innovation Drive, Suite 204
Chesapeake, VA 23320
Phone: 757-277-9927
Fax: 757-277-9928

Thank you for selecting Virginia Rheumatology Clinic as your provider of rheumatologic healthcare services. Please notify us as soon as possible of any changes in your insurance coverage, address, phone numbers, or other pertinent information as it is important that we have your most current information.

FINANCIAL POLICY

INSURANCE PLAN PARTICIPATION: ***Physician participation is subject to change without notice.***
Our physician(s) participate with most insurance plans. If your insurance plan is one with which we are not a participating provider, you will be responsible for payment ***IN FULL*** at the time of service. As a courtesy we will file your insurance claim and have the payment sent to you. In the event that your insurance carrier pays our office directly we will refund to you the payment, minus any copayment, coinsurance or deductible so indicated on your Explanation of Benefits. __________ Initial

COPAYMENTS AND DEDUCTIBLES:
Specialist co-payments and deductibles are due at time of service. _________ Initial

REFERRALS:
Certain health insurance plans require their members to obtain a referral from their Primary Care Physician before visiting a specialist. It is the patient's responsibility to acquire the necessary referral. Alternative payment arrangements or the rescheduling of your appointment may be necessary if proper authorization is not obtained. ________ Initial

SELF PAY:
Payment ***IN FULL*** is expected at the time services are rendered. Alternative financial arrangements must be made in advance of medical treatment. _________ Initial

NO SHOWS:
When you schedule an appointment at Virginia Rheumatology Clinic we reserve that time for you and the doctor. If you are unable to keep your appointment we ask that you give us at least 24 hours' notice. We will reschedule your appointment to a more convenient time for you and give another patient the opportunity to schedule an appointment. A ***No Show*** charge of $25.00 will be posted to your account for failure to present for a scheduled appointment without 24 hours' notice. _____ Initial

CO-PAYMENT PROCESSING:
We accept cash, checks, and credit cards for payment. There will be $35 fee for all returned checks. _______ Initial

*We participate in the **Virginia Prescription Monitoring Program**, we check for prescription history of Schedule II-IV prescriptions.
___________ Initial

I have read and understand this Financial Policy. In the event of non-payment by the insurance carrier, for any reason, I understand that I am responsible for payment of the outstanding balance. Should legal action be required in the collection of an outstanding balance on my account, I understand that I will be responsible for payment of all court costs, collection fees and/or attorney fees equaling thirty-three percent (33%). I have been given the opportunity to ask questions and have received answers to my satisfaction.

____ ______________________

Patient/Guardian Signature Date

____ ______________________

Witness Date