APEX PHYSICIANS
INFECTIOUS DISEASES SPECIALISTS
7312 E. Deer Valley Road, Suite 100 • Scottsdale, Arizona 85255
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APPOINTMENT POLICIES AND FINANCIAL RESPONSIBILITY AGREEMENT OFFICE VISIT/ TELEHEALTH APPOINTMENTS

APPOINTMENT POLICIES

Our office hours are Monday through Friday 8:00am until 4:30pm. Clinic hours vary by provider. We make every effort to schedule your appointment at the most convenient time for you. If you cannot keep your appointment, please let us know of your cancellation as soon as possible so that we may offer the slot to another patient.

A $50 fee will be applied to all missed appointments or late cancellation (appointments cancelled within 24 hours of the scheduled time.) To help remind you of your upcoming appointment, we will send out reminders via text or email. If need be, you will have the opportunity to cancel your appointment by replying to any of these reminder messages. Please bring your insurance card and a photo ID to every visit. Please also include proof of a physical address (i.e. no P.O. box addresses allowed.)

INSURANCE – ALL PATIENTS

We must collect all fees and co-payments that your insurance may require at the time of your visit, including a pre-payment toward any unmet deductible - this is a contractual obligation we have with the insurance companies and these fees cannot be waived. Please make every effort to make sure we are in-network with your specific insurance plan. If your insurer required a pre-authorization for you to see one of our provides, then you are responsible for obtaining that referral or authorization from your primary care physician. We will assist as able, but if an authorization is required and not obtained, then you will be responsible for the full payment of the visit and any associated service fees. We are a third party with your insurance company. Please understand that the Explanation of Benefits that we receive from your insurer is how we apply any payment or deductible to your account. We are not responsible for any discrepancies with your insurance company. We will help provide any necessary medical records (from our physicians) if you need to file an appeal with your insurer.
_____ (Initial)

NON-INSURED PATIENTS & NON-CONTRACTED PATIENTS

This applies to patients who do not have insurance or that have insurance coverage with a plan with which we do not participate (out-of-network). Apex Physicians have made the patient aware that their services will NOT be covered by insurance and the patient agrees to be a self-pay patient. You must make full payment for all services rendered at the time of your visit.
_____ (Initial)

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE MY INSURANCE COMPANY, INCLUDING MEDICARE IF I AM A MEDICARE BENEFICIARY, TO MAKE PAYMENTS TO APEX PHYSICIANS FOR MEDICAL OR SURGICAL SERVICES OR ITEMS RENDERED TO ME OR MY DEPENDENT(S) BY APEX PHYSICIANS. SHOULD MY INSURANCE CARRIER DENY APEX PHYSICIANS PAYMENT, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I AUTHORIZE APEX PHYSICIANS TO RELEASE ANY AND ALL OF MY RECORDS TO MY INSURER, OR ANY OTHER THIRD-PARTY PAYER, LEGALLY RESPONSIBLE FOR THE PAYMENT OF MEDICAL EXPENSES. I CERTIFY THAT THE INFORMATION PROVIDED OR TO BE PROVIDED BY ME IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IT IS MY RESPONSIBILITY TO UPDATE ANY AND ALL PERSONAL, INSURANCE AND HEALTH INFORMATION.

_____ (Initial)

Delinquencies and other fees after 120 days: any delinquent debts will be referred to an outside collections' agency, at which time they will assume full responsibility for your account. If it looks like you will be unable to fulfill your debt within 120 days, please contact our office immediately so that we can help set up a payment plan or make other arrangements. Returned check are subject to a $35.00 insufficient funds charge. This fee is assessed to us by our bank which we then forward on to you.

I UNDERSTAND THAT APEX PHYSICIANS IS NOT RESPONSIBLE AND WILL NOT COMPLETE ANY SHORT-TERM DISABILITY OR FMLA FORMS/PAPERWORK. THIS IS THE RESPONSIBILITY OF THE PATIENT AND/OR THEIR PCP

_____ (Initial)

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, PAID OR UNPAID BY INSURANCE.

By signing below, I indicate that I have read and understood the Appointment Policies and Financial Agreement described above.

_____ _____

Signature of Patient or Legal Surrogate Date Time

_____ _____

Printed Name of Patient or Legal Surrogate Relationship (if Legal Surrogate)