Suncoast Rheumatology

13425 S. Belcher Road, Largo, FL 33771
PHONE (727)223-9610 FAX (727) 303-3193
suncoastrheumatology.com

FINANCIAL POLICIES

Please note that there will be a $25.00 cancellation fee for visits that are not cancelled 24 hours prior to the scheduled time for office visits, infusions or other appointments.

Upon arrival, please pay services incurred or any previous balances that are determined by your insurance to be patient responsibility (including co-pays, deductibles, or previous account balances).

Payment for out-of-pocket expenses is expected at the time of service. Out of pocket expenses may include co-payments, deductibles, co-insurance or payment for any services that your insurance does not cover.

Future visits, diagnostic testing or infusions will be scheduled once outstanding balances are paid or arrangements are made.

We are pleased to file claims with your insurance company, but you are personally financially responsible for healthcare services provided to you by Suncoast Rheumatology.

If your primary insurer (or secondary for Medicare) does not pay your claim within 60 days of its submission, Suncoast Rheumatology will expect direct payment from you.

Patient Name _____ Date of Birth_____

Patient Signature_____ Date _____

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Susan L Zito DO MPH FACR FACOI

To our patients,

The staff at Suncoast Rheumatology wishes to respect your privacy and make all reasonable attempts to enact your preferences regarding your confidential information. With that in mind, please indicate your preferences below.

I wish to be contacted in the following manner (check all that apply):

Home / Cell Telephone _____
_____ Leave a DETAILED message with information
_____ Leave message only with call back NUMBER

Work Telephone _____
_____ Leave a DETAILED message with information
_____ Leave message only with call back NUMBER

Written Communications_____
_____ Mail to my home address
_____ Mail to my work / office address
_____FAX to this number _____

You may speak with the following individuals (spouse, family, caretakers, etc) regarding:
_____ My care or treatment (blood, imaging results, etc)
_____ My bills
_____ My appointments
_____ My prescriptions (giving permission to pick up medication scripts as well)

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that I may revoke this authorization at any time with written notification

Patient Name_____ Date of Birth_____

Signature_____ Date_____

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