Emkey
Arthritis & Osteoporosis Clinic
Comprehensive & Compassionate Care

Ronald Emkey, MD, FACP, FACR
Gregory Emkey, MD
Valerie Galante, MSN, NP-C

Financial Policy

Thank you for allowing the team at Emkey Arthritis & Osteoporosis Clinic to be part of your health care team. We are honored and dedicated to providing you with the best possible care. We ask that you read the following policies and sign below to let us know you agree to follow our company policies.

You are expected to pay your co-pay, deductible and any out of pocket portions at the time of service. For your convenience, we accept payment by cash or check, or credit card for payments greater than $50. If your account becomes past due, you will not be able to schedule a future appointment until it is paid in full or there is an agreed upon payment plan in place with our billing department. Our billing department can be reached at 1-855-326-1251.

Any balance that remains outstanding after 90 days and is not enrolled in an agreed upon payment plan will be sent to a collection agency.

If your benefits change at all during the year, please be sure to inform us as soon as possible so we can update our system. Ultimately, final responsibility for payment of our services is your obligation.

Please be sure to bring your medical insurance card to each visit so we can compare to the one we have on file for you and make a copy if it is different in any way.

High-Deductible Plans: If you participate with a high-deductible health plan, payment in full will be expected at the time of service and we will provide you with an invoice that you can submit to your insurance for reimbursement.

Out of Network: It is your responsibility to understand your out-of-network benefits. Payment will be expected at the time of service and we will provide you with an invoice that you can submit to your insurance for reimbursement.

Referrals / Authorizations: Since we are a specialist practice, your healthcare policy may require a referral from your primary care physician, and if this is the case, it is your responsibility to obtain one and bring it to your appointment. Please be advised that your appointment will be cancelled if your insurance requires a referral and you do not have it with you. Our staff will take care of acquiring any prior authorizations needed for services or medications, however this does not guarantee your insurance will cover the cost.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. Payment will be expected on a monthly basis until the account is paid in full. If you have any questions at all, please contact our billing department directly by calling 1-855-326-1251.

Returned Checks: There is a $35.00 fee for ALL returned checks.

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Missed Appointments: We ask for a minimum of a 24-hour notice for any appointments you cannot keep. Missed appointments and appointment cancellations with less than 24-hours notice will be charged $75 for established patients. If another person or a facility will be bringing you to your appointment and you would like the appointment reminders to be sent to them instead of you, please inform our front office staff so we can make that change for you.

New Patient Appointments: When scheduling an appointment as a new patient, we require a $125 deposit. This money will be refunded to you at your first visit. The deposit will not be refundable for missed appointments or cancellations with less than 24-hour notice.

Medical Record Transfer Fees: There is a fee for the transfer of your medical records to another practice or facility. Records will be released within 5 business days upon receipt of the payment. The fee is per page which is determined by the Pennsylvania Department of Health.

Additional Forms: (i.e., Disability & Family Medical Leave Forms, Worker's Compensation and Parking Placard forms) There is a charge for the completion of additional forms. It is $10 for the first page and $5 for every page thereafter. Forms will be completed upon receipt of the payment by cash or check.

ALL PATIENTS MUST SIGN THIS FORM REGARDLESS OF INSURANCE COVERAGE.

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE:_____