Date: [Insert Date]

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert DOB]
Patient ID/Account Number: [Insert ID Number]

Subject: Financial Responsibility for Rheumatology Diagnostic Consultation

Dear [Patient Name],

This letter serves to outline your financial responsibilities regarding your upcoming rheumatology consultation and the associated diagnostic testing for autoimmune conditions.

The diagnostic process for autoimmune disorders often requires specialized laboratory panels, imaging (such as X-rays or MRIs), and comprehensive clinical evaluations. Please be advised of the following:

- **Insurance Verification:** While we may assist in verifying your benefits, it is your primary responsibility to confirm that our providers are in-network with your specific insurance plan.
- **Authorizations:** Some advanced diagnostic tests (e.g., specialized antibody panels or biologics) may require prior authorization. We will attempt to obtain these, but approval is not guaranteed.
- **Co-pays and Deductibles:** All co-payments are due at the time of service. You are responsible for any remaining balance resulting from your annual deductible or co-insurance percentages.
- **Non-Covered Services:** If your insurance provider deems a diagnostic test "not medically necessary" or "investigational," you will be held financially responsible for the full cost of those services.
- **Outside Laboratory Fees:** Some specialized blood tests are sent to external reference laboratories. You may receive a separate bill from those facilities.

By signing below, you acknowledge that you have read this policy and agree to accept full financial responsibility for all services rendered during your autoimmune diagnostic consultation.

_____
Patient or Legal Guardian Signature

_____
Date

Sincerely,

[Practice Name]
[Rheumatology Department]
[Contact Phone Number]