Regional Hematology Oncology Associates

FINANCIAL AND PAYMENT POLICY

Thank you for choosing Regional Hematology Oncology Associates as your provider. We are committed to providing quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read the policy and ask any question you may have. Please sign in the space provided. A copy will be provided upon request.

1. **Insurance**: We participate in most insurance plans, including Medicare and some Medicaid plans. If you are not insured by a plan that we do business with payment in full is expected at the time of your visit. We will do our best to make you aware of any out of pocket expenses but be aware that is your responsibility to know your insurance benefits.
2. **Copays and Deductibles**: All copays and out of pocket expenses must be paid at the time of service. This is the arrangement that you made when contracting with your insurance company. It is considered fraud by the federal government and a breach of contract with your insurance company not to collect these monies when due. You may, however, make a payment arrangement with our billing department should these expenses be a burden to your financial situation. (See billing personal for these arrangements).
3. **Non Covered Services**: Please be aware that some and perhaps all of the services you require or need for your medical care may be considered by your insurance to be non covered or not reasonably necessary. These services are your responsibility and will need to be paid in full.
4. **Proof of Insurance and Identification (ID)**: All patients must complete our patient information forms before seeing the doctor. We must by law obtain a photo ID and your current insurance cards. If you fail to provide us with the correct insurance information you may be responsible for the balance of the bill.
5. **Claims**: We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with the request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between YOU and your insurance company. We are not a party to the contract.
6. **Coverage changes**: If your insurance changes, please notify us immediately so that your account can be updated with the correct information. This is necessary so that a new benefit investigation can be obtained prior to your next visit.
7. **Non Payment of Bills**: If your account is over 90 days past due you will receive a lette asking for payment. It is your responsibility to contact our billing department to make

payment arrangements or ask for assistance in settling the balance. Failure to do so will result in cancellation of your appointment including treatments.

8. **Missed Appointments**: Our policy is to charge for a missed appointment if you do not notify the office within 24 hours of your appointment time. These charges will be billed to you directly and are not covered by your insurance carrier. We realize that there are exceptions where you cannot contact us in a timely manner. (An example of an exception- admission to a hospital) We ask that your designated emergency contact call for you to notify us of your situation.

Our practice is committed to providing you the best treatment and care. Our prices are representative to the usual and customary fees in our area. Thank you for taking the time to read and understand our policy. We would be happy to address any questions and or concerns you may have.

I hereby authorize and direct payment to Regional Hematology Oncology Associates (RHOA) for benefits if any, otherwise payable to me under terms of my insurance. I am personally responsible for payment if any service is determined to be non-covered, or denied by my insurance carrier. If invalid insurance information is given resulting in nonpayment, I understand that I will be responsible for all balances incurred. This includes any service determined by Medicare to be not-covered.

I have read and understand the payment policy and agree to abide by its terms:

_____ _____

Signature of patient or Responsible Party **Date**

_____ _____

Witness of RHOA **Date**