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FINANCIAL POLICY

Thank you for choosing Wellness Oncology and Hematology to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, of which we require that you read and sign. All new patients must complete our Patient Registration form as well as our Financial Policy before seeing the physician.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.
WE ACEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER.
PAYMENT PLANS ARE ACCEPTED UPON APPROVAL.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We will bill your insurance plan for you, as long as you provide us with correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, ultimately are responsible for payment of all services provided by Wellness Oncology and Hematology. While payment is your responsibility, we will assist you in negotiating settlement with your insurance company for any disputed claim. Our billing department is available to discuss any questions you may have regarding your insurance or your account at (818) 346-1773. Regarding insurance plans where we are a participating or preferred provider. All co pays, deductibles and out of pocket expense are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating or preferred providers, please refer to the above paragraph. If your insurance plan changes you are responsible for informing our billing staff in a timely manner.

If you have a secondary insurance, we will bill it for you, as a courtesy, as long as you have provided us with the appropriate information.

USUAL AND CUSTOMARY: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICAL NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. Therefore, if your insurance company arbitrarily determines that a service we have rendered to you is unnecessary, you will be responsible for the bill.

CREDIT POLICY: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days. We realize it may be necessary on occasion to arrange installment of other payment programs. If financial problems arise, please contact our billing department as soon as possible by calling (818) 346-1773. If an account becomes past due with no valid reason, necessary action will be taken to recover the account balance due. If your account is placed with an outside collection agency, you will be responsible for all collection fees and all legal fees.

Thank you for understand our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date: _____
Signature of Patient or Responsible Party