Virginia Cancer Care

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Practice Financial Agreement Policy

Thank you for choosing our practice for your healthcare needs. The following is a statement of our Financial Policy, which you must read, agree to and sign, prior to treatment. The policy applies to ALL services rendered by our staff whether inpatient or outpatient.

Patient Payment Policy Guidelines:

Patients and their guardians are financially responsible for ALL charges, regardless of third party involvement. Full payment is due at the time of service, unless prior insurance billing arrangements have been made. Patients with insurance will be required to pay ALL "out of pocket" expenses at the time of service. We accept CASH, CHECK, VISA and MASTERCARD.

Patient Responsibilities and Financial Policies:

1. **Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes YOU must inform VIRGINIA CANCER CARE immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.**
2. **Know Your Insurance Coverage, Benefits, and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage benefits and referral requirements to receive diagnostic and therapeutic services in our office. PATIENTS ARE RESPONSIBLE FOR SECURING THE NECESSARY WRITTEN REFERRAL REQUIRED FROM YOUR PRIMARY CARE PHSYICIAN. Please present your insurance ID card to our staff upon arrival for each appointment.**
3. **Self Pay Patients: Patients without insurance coverage are expected to pay for services received in full at the time of service, unless a satisfactory payment agreement had been made with the billing department prior to services being rendered.**
4. **Patients with Private Insurance/Medicare/Medicaid Coverage: Our physician participates with the Medicare and Medicaid programs, and with most major insurance companies. We will file claims to your insurance**

provided you authorize the “assignment of benefits” below for payment directly to our practice. For participating insurance plans the practice will accept payment based on contract agreements. For plans that we do not participate in, the practice will expect full payment at the time of service from the patient. A refund will be made to the patient, if/when a payment is received from the insurance.

Patient Payment Agreement:

I fully understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductibles, coinsurances, co-payment or services deemed non-covered by my insurance carrier at the time of service.

I fully understand that if I fail to pay outstanding balances or make payment arrangements within 60 days the amount due will be considered delinquent and subject to legal action. Should I fail to make payment or arrangements of payment I could be dismissed from the practice. If my account is forced into collections I agree to reimburse Virginia Cancer Care, INC the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys’ fees, we incur in such collection efforts.

I fully agree to pay a $30 returned check fee on any returned checks. Also a $50 missed appointment fee for appointments not cancelled at least 24 hours in advance.

Copies of my medical records can be obtained with advanced notice in accordance with 8.01-413 of the Code of Virginia, with charges to not exceed $0.50 per page for the first 50 pages and $0.25 for the remaining pages thereafter, in addition to the $25.00 handling fee plus postage expense.

The completion of special forms or reports has a charge of $25 PER FORM.

In consideration for medical services rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicated that I have read and agree to the above policy.

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Patient /Responsible Party/Guardian Signature

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Date

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