Chart #_____

FINANCIAL POLICY AGREEMENT

Welcome to the medical practice of Charleston Oncology. We want to inform you of our financial policies prior to your treatment to prevent any misunderstanding; it is our belief that addressing any financial concerns regarding your treatment upfront and as soon as possible is a critical part of your care. If this agreement does not answer any questions you have concerning our financial policies, please do not hesitate to speak with an insurance representative at our practice.

To help us provide the best service possible, complete, accurate, and up-to-date insurance information is a necessity at each visit to the office.

- Insured patients: As a courtesy to you, our patient, we will submit claims to your primary, secondary and/or tertiary insurance plan on your behalf. Insurance coverage varies considerably from plan to plan and we must rely on you to inform us of the appropriate filing order and any special rules your plan requires.
- Your **deductible**, **out of pocket**, **co-payment** and **co-insurance** is **due at the time of service unless other arrangements have been made in advance.**
- Uninsured patients: Full payment is due at the time of service. We may be able to offer a discount based on income. Please ask to speak with a Financial Counselor to see if you qualify for a hardship discount.
- If you are unable to pay in full at time of service, a payment plan agreement may be arranged through a Financial Counselor. This arrangement must be made in advance.
- We will verify your insurance coverage at every visit. Please understand that oncology/hematology claims can be very costly and our extra attention to insurance verification is to limit your chance of receiving a large unexpected bill.
- We do our best to let you know what your approximate cost will be for services and/or treatments, but it is only an ***ESTIMATE***. The true final cost will be determined by your insurance carrier.
- When labs, x-rays or other tests are ordered by Charleston Oncology, you are responsible to notify us if your insurance requires these tests be performed at a specific location.
- Patients requiring <u>referral authorizations</u> must contact our office prior to making arrangements for health care or testing outside of our practice. Any unauthorized charges will be your responsibility.
- We make every attempt to enroll every patient on drug cost assistance programs. You may be required to complete forms and provide proof of finances, i.e., tax documents or social security statements. If you fail to complete the forms and provide the requested information within 30 days, you will be liable for the full balance.
- We accept cash, checks, American Express, Discover, Visa and MasterCard.

By signing this consent, I agree to:

- Accept personal responsibility for all services rendered to me
- Authorize payment of medical benefits to Charleston Oncology for any medical and/or surgical services rendered to me.
- Authorize Charleston Oncology to release any information required in the course of my examination and treatment to my insurance company to assist them in paying my claims.

I have read, understood and agree to the Financial Policy (above).

_____ _____

Signature of Patient Date

_____ _____

Printed Patient Name Date

Received by: _____

Date: _____