

## Patient Payment Policy

Dear Patient,

Thank you for choosing Cancer Care Associates as your health care provider. We are committed to providing you with quality health care. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). Please read the policy and sign in the space provided. A copy will be provided to you upon request. If you have questions, please let us know.

1. **Insurance.** Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your insurance plan for you, as long as you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage.

Non-contracted insurances: if we are not contracted with your insurance company, please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of your costs but the final amount due will be determined by reimbursement from your insurance company.

2. **Non-covered services.** Please be aware that some of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurers.
3. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that charges for services received are your responsibility whether or not your insurance company pays your claim.
4. **Proof of insurance.** All patients must complete a patient information form before seeing the doctor. We will ask for a copy of your current valid insurance card(s) as proof of insurance.
5. **Coverage changes.** If your insurance changes, please notify our Billing Specialist immediately so we can make the appropriate changes to your billing information. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges. You may contact a Billing Specialist at (559) 326-1222 Ext. 108 or 119.
6. **Co-Payments. All co-payments must be paid at the time of service.**  
This arrangement is part of your contract with your insurance company.

7. **Nonpayment.** Please be aware that if you fail to pay your portion of your bill, we may refer your account to a collection agency and you may be discharged from this practice.
8. **Missed appointments.** Our policy is to charge \$25.00 for missed appointments not canceled more than 24 hours in advance. These charges will be your responsibility and billed directly to you. Your insurance will not pay them. Please help us to serve you better by keeping your regularly scheduled appointment.
9. **Payment.** For your convenience, Cancer Care Associates accepts Cash, Checks and Credit Cards. We accept Visa, Master card and Discover.
10. **Financial Counselor.** We have a Financial Counselor available as a resource to our patients. You may contact the Financial Counselor at (559) 326-1222 Ext. 109.

Our practice is committed to providing the best treatment for our patients. Our fees are representative of the usual and customary charges for our area.

Thank you for taking the time to read our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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Relationship to Patient