

# CAROLINA BIOONCOLOGY INSTITUTE

## **FINANCIAL POLICY**

We believe that communicating our financial policy is a good business practice; therefore, we ask that you please read this notice in its entirety and advise us if you have any questions. Understanding your financial responsibilities is essential; it takes a team that includes patient participation, to succeed with insurance processing and reimbursement.

It has become increasingly difficult to collect the fees rightfully due the provider for services rendered, in good faith, to their patients. To this end, we have found it necessary to be explicit in our financial policies. The patient or their legal representative is ultimately responsible for all charges for services rendered regardless of insurance coverage. Insurance is a contract between you and your insurance company. If you do not pay in full at the time of service, we are, in essence, extending interest free credit to you. Unlike many businesses where payment is collected prior to the receipt of any good or service, we generally provide you with a service and then wait to receive payment at later date. Failure by the insurance company to pay, results in the balance being transferred to the patient for payment.

It is your responsibility to provide us with accurate and complete information and keep us up to date of any changes.

### **In-Network/Out-of-Network**

We are in-network with many, but not all, insurance companies. It is your responsibility to contact your insurance to determine if we are in network with them. If we are out-of-network with your particular insurance, insurance payments may come directly to you and you should sign that check over to us as it is payment for services rendered. We will also need the accompanying explanation of benefits paperwork so that we can post the payment appropriately. The exception is if you have already paid in full. Be aware that you may have a higher out of pocket expense by seeing an out-of-network provider. All charges will be transferred to patient responsibility after we have filed your claims as a courtesy. It remains your responsibility to follow up with your insurance if your claim has not been paid after 30 days and to make payment within 30 days from the date of service regardless of whether we have received payment from your insurance or not. If we have not received payment within 30 days of the date of service then, unfortunately, we may have to consider transferring your care to another provider and seek further collection action.

### **Insurance Claims**

As a courtesy, we will file your primary and secondary insurances only. You will be responsible for filing with any additional insurance that you have. Having a secondary insurance does not necessarily mean that your insurances will cover your bill at 100%. Secondary insurances typically pay according to a coordination of benefits with your primary insurance.

### **Copay**

We are obligated per our contract with your health insurance to collect your copay at the time of service. You are obligated per your contract with your health insurance to pay your copay at the time you seek medical care. We cannot bill you for copays.

### **Methods of Payment**

Our office accepts cash, check money order, Visa, MasterCard, and American Express. Please be prepared to pay, at the time of your appointment, any copay, coinsurance, deductible, or outstanding balance due on your account. Our Account Representative will meet with you if you fail to make payment in order to assist you with resolving your account balance. We do offer payment plans and help with applying for financial assistance.

### **Returned Checks**

There is a \$36 returned check service charge. Payment will then need to be made by cash, money order, debit or credit card for the balance due and the returned check fee.

**No Show/Late Cancellation Fee**

If you do not show for your appointment, cancel or reschedule within 24 hours of your appointment time, we will bill you an administrative fee of \$40. Unfortunately, this fee cannot be billed to your insurance.

**Medical Records**

We charge for copies of medical records in accordance with HIPAA, State and Federal regulations. These charges assist in covering the costs of the labor, postage and supplies associated with compiling the copies.

**FMLA, Disability and other Form Completion**

Completing forms requires time away from patient care and day to day business operations. Prepayment of \$20 per form is required. Please understand that in order to complete forms your medical record must be thoroughly reviewed, the forms completed, signed by the provider and scanned into your medical record. Therefore, please allow 5 business days for this process.

**Referral for Outside Collection**

Due to the rising costs of providing healthcare and the decreasing reimbursement by insurances, including Medicare, we cannot carry outstanding account balances. We will work with you to set up a payment plan, if necessary, but balances not paid within 90 days will be reviewed for forwarding to an outside collection agency for further collection action. If this occurs, it may be necessary to terminate care and the patient required to seek an alternate provider. Our collection agency does report to the major credit bureaus (Equifax, Experian, and Trans Union) and this information will show on your credit report.

**Refunds**

Refunds are issued to the appropriate party. Patient refunds will not be issued until all services have been processed by insurance. Refunds less than \$10.00 will not be issued unless requested.

*By signing below, you indicate your understanding this policy and agree to the terms outlined above. You also agree to sign over insurance checks that you receive as payment for services this office and Dr. John Powderly provides to you. You agree that checks will be signed over and submitted to our office no later than 10 days after receipt.*

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

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

If authorized individual, name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_

Date: \_\_\_\_\_

\*Please provide a copy of document of authorization.