CHARLESTON
CANCER CENTER
Dedicated to Your Tomorrow

Charles S. Holladay, M.D.
Douglas L. Michaelsen, M.D.
Julia H. Saylors, M.D.

Robert M. Silgals, M.D.
Ashley A. Jeter, M.D.

FINANCIAL POLICY AGREEMENT

Thank you for choosing us as your Oncology Care Provider. We are committed to providing you with quality and affordable healthcare. This is a policy regarding patient and insurance responsibility for services rendered. Please read and review the policy carefully and sign in the space provided. A copy will be provided to you.

- We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. For those insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help your receive the maximum benefits.
- All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- If your insurance plan requires you to obtain a referral, it is your responsibility to obtain a referral from your primary care physician. If you fail to provide the referral to us, your appointment will be rescheduled or your claim for that date of service will be process via opt-out benefits, if applicable.
- All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- 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.
- If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, this may result in the rescheduling of your appointment. We may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and/or certified mail that you have 30 days to find alternative medical care. During this 30 day period, our physician will only be able to treat you on an emergency basis.

- Our office provides you with monthly statements to include your charges, insurance payments and contractual adjustments along with payments made by you. Please note that failure to pay outstanding balances and/or copays that are your responsibility may result in (a) rescheduling of a future appointment, (b) forwarding your account to a collection agency or collection attorney,(c) discharging you from the practice.
- Our policy is to charge for missed appointments not cancelled within a 24 hour period time. A $25.00 missed appointment fee may be charged to you for any missed appointment where you fail to cancel a scheduled appointment at least 24 hours prior to the time of your scheduled appointment. The fee will be your responsibility to pay and will not be billed to your insurance company.

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

_____ _____

Signature of Patient Date

_____ _____

Print Patient Name Date

_____ _____

Received by CCC Employee Date