

Radiation Oncology Associates, P.C.
Policy for Payment of Accounts

To prevent misunderstandings, please be advised that the patient is ultimately responsible for all bills. If you have insurance, under most circumstances, we will file the health insurance claim for you. However, THE PATIENT is responsible for all deductibles, copays and other allowable balances that his/her insurance does not pay. If you do not have health insurance and are not able to pay your bill in full, we do extend credit to our patients who need it. However, you must request to establish a payment plan before treatment commences.

If you are a member of a Health Maintenance Organization (HMO) or any other health plan that requires referrals and co-payments, it is the office policy to obtain both the referral(s) and the copay at the time you check in for your appointment. If you do not have the required referral(s) for your visit, you are financially responsible for the visit and any related services rendered.

If you do not have your insurance card with you when you register as a new patient, you will be considered as a private pay patient and will be financially responsible for the visit until such time the insurance card is presented to our office. You will be asked to sign a statement of responsibility since your insurance is filed as a courtesy.

Payment Agreement

I agree to pay all amounts for which I am responsible, including but not limited to insurance copays, deductibles, and all balances for which I have no insurance coverage. Further, should it be necessary to refer my account to a collection agency or attorney, I agree to the collection fees described below.

Signature _____ **Date** _____

Spouse's Signature _____ **Date** _____

Assignment and Medical Information Release

I authorize the release of any medical or other information necessary to process medical claims for services furnished by Radiation Oncology Associates, P.C. I authorize the review of my medical records by my health plan for audit purposes.

I authorize payment of medical benefits to Radiation Oncology Associates, P.C. for any services furnished by that establishment through its providers for services as indicated/described on my insurance claim forms.

Patient's Signature _____ **Date** _____

FOR PATIENTS WITH MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Radiation Oncology Associates, P.C. for any services furnished by that establishment. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature _____ **Date** _____

Collection Fees

If this contract or any debt owed to Radiation Oncology Associates, P.C. is referred for collection, I agree to pay all collection fees in the amount of thirty-three and one-third percent (33 $\frac{1}{3}$ %) of the total indebtedness and court costs incurred by Radiation Oncology Associates, P.C. I understand and agree that should Radiation Oncology Associates, P.C. be awarded judgment relating to this contract or any debt incurred thereof, I will pay a service charge of one and one-half percent (1 $\frac{1}{2}$ %) per month; eighteen percent (18%) per annum, beginning on the day of judgment.

Beneficiary Name _____ **Medicare Number** _____