Advanced Oncology Center, Inc.

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Financial Policy

The physicians at Advanced Oncology Center, Inc. are committed to providing you with the best possible medical care, and are pleased to discuss our Professional Fees and Financial Policy. Your clear understanding of our Financial Policy is important to our professional relationship.

- All Patients must complete our "Patient Information Form" before being seen by the doctor and this form must be updated at least once a year.
- Cash patients will need to pay in full at the time of service.
- The payment of any deductible or co-payment is due at the time of service.
- The payment of the balance of any insurance charges that are more than 90 days from the date of service are also due immediately and at the time of any subsequent service.
- We accept cash, check, MasterCard or Visa, American Express and Discover.

A $35.00 fee will be charged for all returned checks.

ADULT PATIENTS:

- Adult patients are ultimately responsible for payment for all medical services.

MINORS ACCOMPANIED BY AN ADULT

- The parents or legal guardians of minors are ultimately responsible for payment for all medical services.

REGARDING INSURANCE

We will bill your insurance **as a courtesy to you,** and we will make every legal and ethical attempt to maximize your insurance benefits. However **you** are ultimately responsible for any deductibles, co-payments, denied or non covered services. We ***cannot*** accept your insurance payment as payment in full. If after **90** days from the date of service we are unable to obtain payment from your insurance company then you will be responsible for payment in full within 30 days.

Medical insurance is a contract between you and your insurance company. We will supply factual information to your insurance company but we will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, non-covered charges, secondary insurance etc.,.

While we know you have to make many decisions regarding medical care, we hope that the quality of service our physicians are determined to provide will be worth the investment that you make in your health care.

If there are any changes made to your Health Coverage/Medical insurance during the course of your treatment, all unpaid claims will become your *total financial responsibility.*

I have read and understood all the above mentioned terms of this "Financial Policy"

_____ Date: _____

Signature of Patient /Legal Guardian

_____ _____

Responsible Party to Patient Translator

Patient Name: DOB: