CANCER CARE ASSOCIATES OF YORK
FINANCIAL POLICY

Thank you for choosing Cancer Care Associates of York as your health care provider. We are committed to the success of your medical treatment and care.

The following is a statement of our Financial Policy which we require that you read and sign prior to being seen. Please let us know if you have any questions. Our staff will be happy to assist you so that you clearly understand our policy.

Insurance & Payment Policy

Please understand that as your healthcare provider our relationship is with you, not your insurance company. We do not become involved in disputes between you and your insurance company regarding deductibles, co-payments, non-covered or denied services.

It is your responsibility to inform us of any changes to your employer or insurance coverage before services are rendered.

If you do have health insurance, we will be submitting your medical bills to the appropriate insurer, including Medicare, and you will assist us with seeing that the necessary paperwork and information is given. "You agree that you will assign to Cancer Care Associates of York any benefits paid directly to you from your insurer for services rendered by Cancer Care Associates of York," and you will pay any balance that is not paid by your insurance. It is your responsibility to inform us of any insurance changes as soon as they occur.

If your insurance company is one that we do not participate with, you will receive a statement until the balance has been paid in full. Once we receive payment from your insurance company, you must pay any balance remaining.

If we do participate with your insurance company, we will accept the contracted payment that has been agreed upon with your insurance company; however, you are responsible for payment of any deductibles, co-insurance or co-payments.

Co-payments for office visits are your responsibility and we expect payment at the time of service.

If you **do not** have health insurance, you must pay your bill at the time services are rendered. If you are having financial hardship, you will be referred to meet with our Patient Financial Advocate to see financial assistance if available, and if you meet the financial guidelines.

You will receive a billing statement from us on a monthly basis. It will show what has been billed to your insurance company, and what balance you owe. The first statement will show the date of service and will itemize the charges but subsequent statements will show only a balance forward with any new charges itemized.
We accept cash, checks, Visa, MasterCard, and Discover for payment.

A $25 fee will be charged for all returned checks, and you will be responsible to pay the returned check fee should that occur.

Referrals/Authorizations

If your insurance plan requires a referral for you to be seen in our office, it is your responsibility to obtain a referral from your PCP (primary care physician) and present it at the time of your initial visit. For subsequent visits to our office, as a courtesy to you, our office will contact your PCP and obtain any necessary referrals.

If you do not obtain a referral from your PCP for your initial visit to our office, you will be responsible for payment of the services performed.

Usual and Customary Fees

Our practice is committed to providing the best treatment for our patients and we feel our charges are fair. You are responsible for payment of your portion of any bill regardless of any insurance company's arbitrary determination of "usual and customary" fees.

Premium Payments

You are personally responsible to pay Cancer Care Associates of York in full for services including chemotherapy that your health insurer will not cover due to nonpayment of your health insurance premiums.

CANCER CARE ASSOCIATES OF YORK FINANCIAL POLICY

I acknowledge that I was given a copy of the Financial Policy of Cancer Care Associates of York for my personal review.

Print Your Name: _____DOB:_____Acct#:_____

Signature: _____

Date: _____

If you are a Legally Authorized Representative signing on behalf of a patient, complete the following:

Print Patient's Name: _____

Indicate Your Relationship (check one):

- ☐ Parent
- ☐ Spouse
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other: _____