**HEMATOLOGY & ONCOLOGY CONSULTANTS OF PENNSYLVANIA, P.C.**
**101 ERFORD ROAD SUITE 101**
**CAMP HILL, PA 17011**

## FINANCIAL POLICY

We are committed to providing you with the highest quality healthcare while assisting you in affordable treatment. To do this, we need your help. We ask that you please read our financial policy below.

1. **PAYMENT:** Payment is expected at the time of your visit. We will accept cash, checks or credit cards. Payment will include any unmet deductible, co-insurance, copayment amount or non-covered charges from your insurance company. If you do not carry insurance, payment-in-full is expected at the time of your visit. Patients who do not have insurance or have large out of pocket amount can make payment arrangements with the billing department. **You are responsible for payment for all services**.

2. **INSURANCE:** We are participating providers with several insurance plans. We will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment-in-full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

   We will not become involved with disputes between you and your insurance company regarding deductibles, co-payment, covered changes, policy etc. **PLEASE** read your policy carefully. In the event your insurance plan determines a service to be "**not covered,**" **you will be responsible** for the complete charge. Payment is due upon receipt of a statement from our office.

3. **FORM FEE:** There is a charge for completing forms, copying and faxing medical records. The charge is determined by the complexity of the form, letter or communication.

4. **RETURNED CHECKS**: All unpaid checks returned to us for any reason, non-sufficient funds, etc. will incur a $40.00 charge and must be paid-in-full within twenty-four (24) hours. We may request all future payments to be cash payment or money order.

5. **LATE CHARGES**: A $10.00 late fee will be applied to all patient balances 90 days old or greater. If your account becomes delinquent, you will be responsible for additional collections fees and/or costs.

6. **NO SHOW POLICY**: At the discretion of the Practice Administrator and/or Doctors, a $65.00 charge may be assessed for all missed appointments. A $65.00 charge may be billed for broken appointments unless a 24-hour notice is given for cancellation. If the office visit is a new patient visit the charge will be $125.00.

It is the policy of Hematology & Oncology Consultants of Pennsylvania to maintain a trusting physician-patient relationship with its patients. Failure to pay for services rendered, consistent with our policy, may result in loss of this trusting relationship and may lead to release of a patient from the practice.

If you have questions in regard to any of your billings feel free to contact our Billing Department at 717-975-8954 Monday through Friday 8:00 A.M to 4:30 P.M..

I have read and understand the practice's financial policy and I agree to be bound by its terms.

**Patient or Responsible Party Signature:**______________________________ **Date** ____________