**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 expert, compassionate, state-of-the-art care. In order for us to be able to properly care for you we would like you to avoid unforeseen expenses, therefore, we recommend you discuss our professional fees and financial policy with the billing department. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

**You are responsible for payment of all services we provide to you. Payment in full is due at the time of service for non-covered services. We accept cash, checks, MasterCard, Visa, Discover, American Express, and debit cards.**

## REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. We will need a copy of your insurance cards and all necessary insurance information for processing claims. If your insurance company does not pay the practice within 45 days, we will have to look to you for full payment. If we later receive a check from your insurer, we will refund any overpayment to you. You are still responsible at time of service for all non-covered services.

We will not become involved with disputes between you and your insurance company regarding deductibles, co-payments, covered charges, policy, etc. **PLEASE** read your policies 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.

You are responsible for the timely payment of your account. If you have an HMO plan, please obtain the referral from your primary care physician **for all services**. If referral authorizations are not available, your appointment must be rescheduled.

**You are responsible for payment of all non-covered services, co-payments, deductibles, and any other applicable amounts at the time of service. This includes major medical plan balances. (Please refer to the Major Medical Notice.) Based on your individual insurance plan, you may be charged a co-pay for services rendered in the office when you do not see the physician. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.**

**If you fail to make us aware of insurance changes within thirty (30) days of the change and your insurance carrier refuses payment to us, you will be financially responsible for payment of services. _____**

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

There is a charge for completing forms, copying, and faxing.

Please check-in upon arrival at the receptionist desk and present your insurance cards. If/when your insurance coverage, employment or care status may change it is your responsibility to inform our office.

**All patients must pay their co-payment amount upon check-in. If unpaid at time of visit a $10.00 delinquent fee is added immediately. _____ (patient's initials)**

**All patients must stop at the checkout desk after every appointment.**

**Page 2 Financial Policy**

If you have a managed care plan in which we do not participate and we are unable to order tests and refer you as needed, we are unable to care for you. Please note if we are out-of-network for you, your out-of-pocket expenses must be paid at time of services.

**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 payments or money orders.**

**A $10.00 re-billing charge is added to all unpaid mailed bills. If your account becomes delinquent, you will be responsible for additional collection fees and/or costs.**

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

**Patient or Responsible Party Signature:_____ Date:_____**

**Printed name of patient**: _____

**Co-sign (Spouse) (Co-Guardian):_____Date:_____**

1. Original copy in patient chart
2. Copy to patient

_____

Witness Date

**Billing Department Counseling**

_____

Billing Department Employee Date

**I authorize HOCP to charge my credit card should I call in to pay over the phone:**

_____

Patient Signature Date