REGIONAL
MEDICAL ONCOLOGY CENTER

Financial Policy

Thank you for choosing Regional Medical Oncology Center (RMOC). Our main concern is that you receive the proper and optimal treatment needed to restore your health.

So that we may better serve you, we ask you to please read, sign, and return this form to us prior to treatment. If you have any questions or concerns regarding our payment policies, please do not hesitate to discuss them with us.

- Co-payments for office services are required at the time of registration.
- We accept cash, checks, debit cards, Visa, MasterCard, and Discover. A $25.00 fee will be charged for returned checks.
- As a courtesy, we will process and file your insurance claims for you.
- In addition to co-payments, any unmet deductible or co-insurance of services will be paid each visit, unless payment arrangements have been made. A billing associate is available at any time to discuss payment plan options.
- We reserve the right to apply overpayments to unpaid account balances prior to patient refunds.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I understand that it is my sole responsibility to verify insurance coverage and I am ultimately responsible for payment in full for any outstanding balances. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform RMOC of any changes associated with my insurance status. Even though I may have health insurance coverage, I understand payment for services is ultimately my responsibility. I understand that payment for services is due at the time that service is rendered unless other financial arrangements have been made. ***Initial Here:*** _____

I hereby guarantee payment of all charges incurred at RMOC. I hereby assign and direct to pay any and all benefits for medical services under this claim to RMOC. I authorize the release of any medical information necessary to process my claim with the above assignment. I also authorize RMOC to file an appeal on my behalf in the event of a claim denial. ***Initial Here:*** _____

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Signature of Patient/Responsible Party **Date**

Medicare Patients Only:

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-insurance, if there is no secondary insurance.

I authorize assignment of Medicare benefits to RMOC for any services furnished by that physician/provider. I understand my signature authorizes release of medical information necessary to pay the claim.

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Signature of Patient/Responsible Party **Date**