



HOA CANCER CENTER  
8166 Douglas Road  
Lambertville, Michigan 48144

## FINANCIAL POLICY

### YOU MUST PRESENT YOUR INSURANCE CARD AT EVERY VISIT!

If your insurance company requires you to have a referral from your primary care physician in order to be treated by a specialist, it is your responsibility to verify that the referral is in place. If a referral is not in place, your appointment will be rescheduled.

Co-Pays must be paid at the time services are rendered, as required by your insurance company. We accept cash, check or credit card. **A \$5.00 billing charge will be added to all co-pays not made the day you are treated.** There will be a \$30.00 fee for all returned checks.

If you do not have insurance, you will be required to pay for services at the time they are rendered, unless other arrangements have been made with us.

It is your responsibility to assign a responsible party to ensure that your account is paid in full in the event of your incapacitation.

As a courtesy, we will file primary and secondary insurance claims for you. **It is your responsibility to assure that we are provided with accurate information in order to process your claims. Please inform us of any insurance changes.** You will be responsible for charges related to claim denials, which occur as a result of your failure to provide us with accurate insurance information.

For our patients who are Medicare beneficiaries, we are "participating physicians." This means that we will accept Medicare's allowed amounts for the services rendered, and Medicare will send payment to us. You are responsible for 20% of the approved charge, as well as your deductible. **If you have a secondary insurance, it is your responsibility to notify Medicare to cross-over claims.** For your convenience, we can provide you with a cross-over request letter form.

There will be a \$25 fee to process disability and Family Medical Leave Act forms. Please leave these forms with the receptionist at the front desk. The form(s) will be completed and mailed to you within 10 business days, or you may arrange to pick these up at the office.

Copies of your medical record are available, there will be a fee charged determined by the number of pages requested.

You will receive a statement from this office monthly. Please pay your bills promptly. If you are having difficulty in keeping your account current, please call Patient Accounts immediately. We may be able to set up a payment plan for you. Accounts that are 90 days past due will be subject to collection action. Any legal activity could cause a breach in the physician-patient relationship, resulting in discharge from the practice. There will be a 25% collection fee charged to your account, payable by you if your account is sent to a collection agency for payment.

I authorize HOA Cancer Center, to release pertinent medical information to my insurance company when requested to facilitate payment for services.

I have read, understand, and agree to the above Financial Policy of HOA Cancer Center. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to HOA Cancer Center.

In the event of my incapacitation, I authorize \_\_\_\_\_ as the responsible party on my account.

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Printed Name

Date

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Signature of Patient

Date

Thank You,  
HOA Cancer Center