CALIFORNIA CANCER CARE

CALIFORNIA CANCER CARE, INC.
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FINANCIAL AGREEMENT

Dear Patient,

This letter summarizes our billing policies, insurance billing procedures, and collection policy. Our goal is to assist you as much as we can with the financial aspects of your care, and our policy is designed to keep costs as low as possible for all of our patients. A copy of this letter will be provided to you at your request.

Each month you will receive a statement from us describing your current balance and any charges incurred during the month. We will submit these charges along with any appropriate forms to your primary insurance carrier for you. We are pleased to provide this service for you.

Although we shall help as much as possible, responsibility for handling problems with insurance reimbursement rests with you. Health insurance coverage varies and not all services may be covered. If your claim is denied, you remain responsible for payment of your bill. If you are a Medicare patient, it is important for you to know that we do accept assignment from Medicare. You are responsible, therefore, for your deductible and co-payments unless you receive services not covered by Medicare. We do **not** bill secondary insurance (with the exception of Medicare supplemental). Please discuss all billing problems with our billing office.

Co-payments for office visits are expected at the time of the visit. Payment for billed services is expected within 30 days of receiving your statement. Charges are considered delinquent after 60 days. If no payment is received within 60 days, a monthly rebilling fee of $12.50 will be imposed for each additional month this amount remains unpaid.

My signature below indicates that I have agreed to the above billing policies and grants California Cancer Care permission to submit insurance claims on my behalf and also to disclose any additional information needed to determine insurance benefits. I request that payment of authorized Medicare or insurance benefits be made on my behalf to California Cancer Care. I am responsible only for the deductible, co-payments, and non-covered services. This agreement will remain in effect for the duration of my care at California Cancer Care.

PATIENT
SIGNATURE _____

DATE _____