Financial Policy and Authorization to Bill Insurance

Each patient should check with Member Services of their insurance plan to understand their specific benefits. Our clinic does not verify benefits on your behalf. We can provide you with an Insurance Benefits Verification form to help you get this information from your insurance company. Patients not utilizing insurance will be asked for payment at the time of their appointment.

Please initial each of the following statements:

_____ I understand that if I am providing insurance billing information, I am responsible for all charges, whether or not they are covered by my insurance.

_____ I understand that co-pays and charges for supplement purchases are due at the time of visit.

_____ I understand that a 24-hour notice is required for all cancelled appointments. Cancellations made less than 24 hours before the appointment time will incur a $45 late cancellation fee, billed to the credit card on file. Each patient's first late cancellation will not be charged. In addition, we are always happy to forgive this policy in the face of extenuating circumstances.

_____ Phone appointments are typically not covered by insurance companies and will incur the same fee as office visits depending on their complexity. You will not be charged if you are calling with a question of clarification on your current treatment plan or if the doctor has asked you to call.

_____ I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month.

_____ I understand that any guarantor who is financially responsible for my account is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance, and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

_____ I understand that some insurance companies may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Sage Cancer Care to release all medical information, including copies of treatment notes, necessary to secure payment of benefits from my insurance specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS, and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

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Printed name of Patient or Guardian/Representative and Relationship to Patient

_____ _____

Signature of Patient or Guardian/Representative Date