MRN:

cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

PATIENT PAYMENT POLICY

Dear Patient,

Thank you for choosing cCARE as your health care provider. We are committed to providing you with quality health care. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). Please read the policy and sign in the space provided. A copy will be provided to you upon request. If you have questions, please let us know.

1. **Insurance.** Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your insurance plan for you, if you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage.
   a. Non-contracted insurances: if we are not contracted with your insurance company, please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of your costs but the final amount due will be determined by reimbursement from your insurance company.
2. **Non-covered services.** Please be aware that some of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurers.
3. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that charges for services received are your responsibility whether or not your insurance company pays your claim.
4. **Proof of insurance.** All patients must complete a patient information form before seeing the doctor. We will ask for a copy of your current valid insurance card(s) as proof of insurance.
5. **Coverage changes.** If your insurance changes, please notify our office immediately so we can make the appropriate changes to your billing information. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.
6. **Co-Payments. All co-payments must be paid at the time of service.** This arrangement is part of your contract with your insurance company.
7. **Nonpayment.** Please be aware that if you fail to pay your portion of your bill, we may refer your account to a collection agency and you may be discharged from this practice.
8. **Missed appointment policy.** Our policy is to charge an assessment fee to patients who miss their appointments, or who cancel an appointment with less than 24 hours' notice.
   Fees: $50.00 fee per missed office visits.
   $100.00 fee for procedure visits.
   $150.00 fee for missed PET Scan visits.
   These charges will be your responsibility and billed directly to you. Your insurance will not pay them. Please help us to serve you better by keeping your regularly scheduled appointment.
9. **Payment.** For your convenience, cCARE accepts Checks and Credit Cards. We accept Visa, Master card, Discover and American Express.
10. **Financial Counselor**. We have a Financial Counselor available as a resource to our patients.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

Signature of Patient or Responsible Party	Date
Print Name	Relationship to Patient

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NO-SHOW / LATE ARRIVAL POLICY & ELECTRONIC COMMUNICATION POLICY

In an effort to maximize the time your physician spends with you and minimize your wait time, we have made changes to our No-Show and Late Arrival Policies as follows.

NO SHOW POLICY

Effective April 1, 2018, we will implement a "no-show" policy which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

- First occurrence - Patient/parent will receive a letter advising of our policy.
- Second occurrence - Patient/parent will receive a second letter and a $50.00 no-show fee assessment for office visits and a $100.00 no-show fee assessment for procedure visits.
- Third and subsequent occurrences - May result with an additional $100.00 no-show fee.

LATE ARRIVAL POLICY

Patients arriving more than 10 minutes late for a scheduled office visit or procedure appointment will be rescheduled for another day.

ELECTRONIC COMMUNICATIONS

For your convenience our office communicates through different electronic means including our secure patient portal, phone, and text messaging for appointment reminders.

Please check below if you do NOT want to be contacted by cCARE in any of the following methods of communication:

☐ Cell Phone ☐ Text Message ☐ Home Phone ☐ Secure Email ☐ Online Patient Portal

Is it okay to leave a detailed message on your voicemail? ☐ Yes ☐ No

Signature of Patient or Representative _____ Date _____

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ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that California Cancer Associates for Research and Excellence has provided me a copy of its notice of privacy practices and I have reviewed the notice. I understand that I may request a copy of cCARE's notice of privacy practices for my records, and that a copy of the current notice will be posted at cCARE's office and on cCARE's website.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

Date of Birth: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ Guardian, personal representative or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____