BPN

Surgical Oncology Associates of South Texas

Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you the highest level of care. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

Unless you are a member of one of our contracted insurance plans, or Medicare, full payment is due at the time of service. We accept cash, checks, Visa and MasterCard.

POS/PPO PLANS

If the physician is contracted with your plan, the majority of members covered under this type of plan are still required to make some type of payment for service that is rendered to them. This may be in the form of co-payment, deductible, or co-insurance. If your plan has a co-payment, you will be expected to pay your co-payment prior to being seen by the doctor. Co-payments, deductibles and co-insurance are requirements of your insurance plan and we are required under our contract with these plans to collect these amounts from you.

HMO PLANS

Most of the members covered under and HMO plans also owe co-payments. Co-payments will be collected prior to being seen by the doctor. We are required under our contract with these plans to collect these amounts from you.

BALANCES ON ACCOUNT

All previous balances are to be paid in full prior to additional services being rendered.

COLLECTIONS

Should it become necessary for us to utilize the services of an outside collection agency in order to collect the amounts that are owed, you will be liable for agency/attorney fees.

ASSIGNMENT OF BENEFITS AND MEDICAL RECORD RELEASE

I hereby authorize my insurance benefits to be paid directly to the above-signed physician realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers. Further I understand and acknowledge that I am ultimately responsible for the financial liability of the services provided.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy and understand and agree to adhere to this Policy.

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Signature of Patient or Responsible Party **Date**