

Alaska Oncology and Hematology, LLC
FINANCIAL POLICY

Patient Name: _____

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Our practice believes that a good provider-patient relationship is based on understanding and good communication. The following is a statement of our Financial Policy, which we require that you read and sign before any treatment.

Our practice accepts most major insurance companies. All patients must complete our patient registration form and give us the necessary information before seeing a provider.

We require payment of your deductible, or your co-payment, at the time of service, unless other arrangements have been agreed upon. We accept cash, personal checks, MasterCard, Visa and American Express.

You are responsible for any portion of your bill that your insurance carrier denies or does not cover. Your insurance coverage is a contract between you and your insurance carrier; however, we are available to assist you in maximizing your insurance benefits.

Please be aware that few insurance companies attempt to cover all medical costs. Some pay fixed allowances for each procedure while others pay only a percentage of the costs. Many insurance companies use a fee schedule derived from providers outside this region and that may not be applicable for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Returned checks are subject to additional collection fees. Charges may also be made for broken appointment and appointments canceled without 24 hours advance notice.

If you have any questions concerning our Financial Policy, or if this creates undue hardship, please contact our Reimbursement Manager, Wendy Johnson at (907) 279-3155 immediately to discuss special arrangements.

By signing below, I verify that I have read and understand this Financial Policy and I authorize Alaska Oncology and Hematology, LLC to release medical records to my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Alaska Oncology and Hematology, LLC if not paid in full at the time of service. I agree that a reproduced copy of this authorization will be as valid as the original. I understand I am responsible for any amount not covered by my insurance.

Signature of patient or responsible party

Date