

## **Cumberland Nephrology Associates Office and Financial Policy**

Welcome and thank you for choosing Cumberland Nephrology Associates for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Letting you know in advance of our office and financial policy, allows for a good flow of communication and enables us to achieve our goal. Please read each policy carefully and sign your acknowledgement where indicated. If you have any questions, do not hesitate to ask a member of our staff.

### **General:**

- Our office hours are Monday through Friday 8:30 am – 5:00 pm. Our answering service is available after hours and on weekends.
- Any returned check from the bank for non-payment, will be charged a \$30.00 fee.
- We will provide you with 1 (one) free copy of your medical records. Any requests for records after this will be charged at a rate of \$1 per page.
- There is a charge of \$20.00 per form fee for the completion of paperwork or forms relating to disability. This fee is collected prior to the return of the completed forms and for each time the paperwork is required. Allow 3 (five) working days for completion of forms. In order to complete “Clearance” request forms, a visit with the examining doctor must be scheduled a week in advance.

### **Appointments:**

- Please inform the receptionist of any demographic (phone number, address, insurance information, etc.) or insurance changes. If you insurance company you designate is incorrect, you will be responsible for payment of the service and to submit the charges to the correct plan for reimbursement.
- 24 hours notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a \$50.00 fee.
- No-Show appointments will be charged a \$50.00 fee. After the 3<sup>rd</sup> No-Show, you will be discharged from the practice.
- Patients that are more than 15 minutes late for their scheduled appointment will be rescheduled.

## **Financial Policy**

### **Insurance:**

- Our office will file insurance claims for all reimbursable services, to your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, coinsurance and non-covered service amounts. We accept cash or check only.
- You will receive billing statement(s) from our office for account balances that are your responsibility. Payment in full is due within 15 business days and if not paid, collection efforts will be made.
- You are responsible for any and all co-payments, deductibles and coinsurances. These are to be paid at the time of service. All balances must be paid before any further services will be provided.
- If you have no insurance or if our physicians do not participate in your insurance plan, payment in full is expected from you at the time of service.
- If your insurance plan requires a referral, it is your responsibility to obtain that referral prior to your visit. If you are unable to obtain the referral for your visit, you may be rescheduled or required to sign our Responsibility Waiver form.

I have read and understand this office and financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Responsible Party : \_\_\_\_\_