KIDNEY CLINIC

Financial Policy

We are committed to meeting your health care needs. In order to keep financial arrangements as simple and cost effective as possible, we have implemented the following guidelines:

1. Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

2. An insurance card is required at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, or credit cards. Any returned checks will result in a $30 returned check fee being added to your account

3. 24-hour cancellation notice required. If no notice is given a $25 no-show fee will be added to your account

4. It is your responsibility to contact your insurance carrier to confirm that our physician participates in your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.

5. If your plan requires a referral, it is your responsibility to obtain this authorization prior to being seen by the doctor.

6. All medical record requests MUST be in writing and received in our office a minimum of 72 hours prior to the date needed. We will require the complete name address where records are to be mailed. There is a $10 administration fee and copying fee per page plus postage, for all medical records. This fee must be paid in advance.

** R**emember that you, the patient, are ultimately responsible for payment. ****

I have read and understand the office policy stated above and agree to accept financial responsibility as described.

_____ _____

Patient Name (PRINT) Patient Signature Date