



## Financial Policy

Thank you for choosing *Maine Center for Cancer Medicine & Blood Disorders* to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign.

All new patients will be asked to complete our Patient Registration form as well as our Financial Policy before seeing the physician.

*PLEASE PRESENT YOUR INSURANCE CARD(s) AT EVERY VISIT*

*ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE*

*IF YOU HAVE NO INSURANCE COVERAGE, PAYMENT IS DUE AT THE TIME OF SERVICE  
UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE*

*FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECKS, VISA & MASTERCARD*

*PAYMENT PLANS ARE ACCEPTED UPON PRIOR APPROVAL*

**REGARDING INSURANCE:** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you as long as you provide us with the correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, are ultimately responsible for payment of all services provided by our facility. While payment is your responsibility, we will assist you with disputed claims. Our Patient Accounts Department is available to discuss any questions you may have regarding your insurance or your account at 885-7601.

Regarding insurance plans where we are a participating or preferred provider, all copays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating or we are not preferred providers, refer to the above paragraph.

If you are in the process of changing your primary care provider and this is the first visit to one of our physicians, it is your responsibility to contact your insurance company to change the provider on their file. If this has not been done, you will be responsible for payment in full for the visit.

If you have secondary insurance, we will bill it for you, as a courtesy, as long as you have provided us with the appropriate information.

If you request to bill your insurance yourself, please do so promptly, so that you will receive reimbursement before your account is considered delinquent.

**USUAL AND CUSTOMARY RATES:** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**MEDICALLY NECESSARY CARE:** We will only provide you with a service if we consider it medically necessary. Therefore if your insurance company arbitrarily determines that a service we have rendered to you, is unnecessary, you will be responsible for the bill.

**CREDIT POLICY:** Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 90 days when a fee of twenty-five (\$25) dollars will be applied and the account turned over for professional collection. Returned Checks will also be assessed a twenty-five dollar (\$25) returned fee for processing.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our Patient Accounts Representative as soon as possible by calling **885-7601**.

***If an account becomes past due with no response from you, necessary action will be taken to recover the account balance due.***

Thank you for taking the time to read and understand our financial policy. Please let us know if you have any questions.

I have received, understand and agree to MCCM's Financial Policy.

Signature: \_\_\_\_\_ Date; \_\_\_\_\_

Printed Name: \_\_\_\_\_