Lancaster Cancer Center
Care Beyond Treatment

Patient Financial Responsibility Policy

Lancaster Cancer Center, Ltd appreciates the confidence you have shown in choosing us to provide for your Hematologic and/or Oncologic needs and we are committed to providing you with the best possible care. The medical services you seek imply a financial responsibility on your part. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to ask any questions regarding your financial responsibility.

Our receptionists will ask to see your insurance card at every visit and will scan your card into our system as needed to keep our information current and to facilitate accurate insurance billing.

Co-payments: Your insurance plan determines your co-pay, and we require payment at the time of service. Please be prepared to pay the co-payment at each visit. If you are unable to pay your co-payment at the time of your visit, your appointment may have to be rescheduled.
** Patients may encounter additional fees for teaching prior to planned infusion room visits. Your insurance company will bi billed initially.

Cost Shares: you will be responsible for you cost share prior to the administration of any treatment. The cost share will be determined by our Financial Counselor and will be discussed wit you prior to treatment.

Cancellation/Missed Appointment: If you do not show for your appointment or cancel with less than 24 hours' notice, a fee of $25 will be charged to your account. This charge will neither be submitted nor paid by your insurance company. It is your responsibility. For further information regarding Cancellation/Missed Appointments please refer to out "Missed Appointment Policy".

Self-Pay: You will be considered self-pay if you have no insurance coverage. Payment is expected at the time of service. **A $100 deposit** is required at the beginning of your appointment with the balance to be paid after your visit is completed. If you are unable to pay the balance in full, you must meet with the Business Office to determine payment options; however, all balances must be paid within 30 days.

Non-Participating Insurance Plans: As a courtesy to our patients, Lancaster Cancer Center will bill your non-participating insurance plan. However, **a $100 deposit** is required at the beginning of your appointment. Any outstanding balances are the responsibility of the patient and must be paid within 30 days.

Referrals: if your insurance plan requires a referral form from your Primary Care Physician, it is the patient's responsibility to obtain a referral prior to your appointment and to have it with you at the time of your appointment. If you do not have the referral, **YOU MAY BE REQUIRED TO RESCHEULE** or sign a waiver accepting financial responsibility for the service.

Medicare: Lancaster Cancer Center will submit your claim to Medicare and upon receipt, will bill your secondary insurance if one applies. The patient will be responsible for the deductible and the co-insurance if you do not have a secondary insurance.

Disability/FMLA/Insurance forms: Each form requires a $25 pre-payment (first form) before the form(s) are completed. These forms take 7-10 business days to complete. Any additional forms in the calendar year will be charged $10 form completion.

Return Check Fee: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $35 fee per check returned.

Additional Billing: In case of hospitalization you will receive separate bills for the related services from the physicians at "Internal Medicine Consultants of Lancaster County". This group manages many of our admission.

Financial Responsibility of Patient:

I understand I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY MY INSURANCE which are collectable in accordance with the contract. I understand it is my responsibility to pay any incurred balance within 30 days of receipt of your billing statement. Should collection proceedings become necessary to an overdue account, the patient of the patients' responsible party understand that Lancaster Cancer Center has the right to disclose to an outside collection agency all relevant and personal account information necessary to collect payment for services rendered. The patient or responsible party understands that they are responsible for all costs incurred during the collection process.

I hereby authorize Lancaster Cancer Center to release all medical information to insurance carriers and/or Center for Medicare/Medicaid concerning my illness and treatment and I hereby assign payment to Lancaster Cancer Center for services rendered to myself/my dependent.

By signing below, I agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party. My signature verifies that I have read the above financial policy, understand my responsibilities, and agree to these terms.

For your convenience we accept CASH, CHECK, MASTERCARD, VISA, DISCOVER, and AMERICAN EXPRESS.

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Signature of Patient, Power of Attorney Date

_____ _____

Witness Date