Financial Policy

It is the policy of **Central Alabama Radiation Oncology, LLC** that all fees including co-pays, deductibles and non-covered services are *due and payable on the date of service unless other payment arrangements have been made in advance*.

Insurance coverage is considered by **Central Alabama Radiation Oncology, LLC** as an agreement between the patient, the insurance company and the employer, where applicable. **Central Alabama Radiation Oncology, LLC** is not a party to that agreement and as a result is not bound by any of the covenants, limitations, or restrictions of that policy.

As a *service to our patients*, we will file insurance claims for the services provided. Itemized bills will be provided to you for those services upon request. The filing of insurance does **NOT** release the patient from responsibility for charges for services which have been provided.

Charges for services **not covered by insurance** are due when a patient statement is received unless specific arrangements have been made for an extension of time. If you have special needs, contact our Billing Office for assistance. **You are responsible** for payment of services not paid in whole or in part by your insurance.

Statements showing the status of your account are mailed monthly. **Central Alabama Radiation Oncology, LLC** is prepared to counsel any patient experiencing difficulty in meeting payment obligations. If you are unable to make payment when due, please contact our office as soon as you receive our statement.

Central Alabama Radiation Oncology, LLC will use the services of an outside collection company in the collection of all debt accounts which are not paid within 90 days and for which no special arrangements have been made. You will be responsible for any fee(s) charged in collection of the lawful debt to include; collection agency fee(s), (33.33%), attorney fees, and/or court costs, if such is necessary.

Having read and understood **Central Alabama Radiation Oncology, LLC Financial Policy**, I agree to the terms set forth.

_____   _____
Patient Signature   Date