CARO | CENTRAL ALABAMA RADIATION ONCOLOGY

Insurance claims are completed without charge as a courtesy to our patients. We reserve the right to accept insurance assignment based on your services and/or treatment. If we accept assignment, we will allow up to 45 days for payment from your insurance carrier. Your Insurance policy is a contract between you and the insurance company. Assignment of benefits does not relieve you of your obligation to assist in the collection of said insurance benefits and pay any uncollected balance due for the services rendered to you. Additional information regarding our financial policy will be provided by you. A counselor from our Business Office will review your insurance coverage and estimate your portion of the bill. The patient balance is due at the time of service.

For assigned benefits, I request that my payment under my insurance plans be made to Central Alabama Radiation Oncology for any medical services and treatment rendered to me. I also request that Central Alabama Radiation Oncology submit a claim to my insurance carrier(s) for payment and authorize payment directly to Central Alabama Radiation Oncology. I hereby authorize release to my insurers all billing and medical information regarding services and treatment rendered for the purpose of determining eligibility for and payment of charges for services and treatment rendered. Should an insurance payment be received that is less than the physician's actual charges for services provided, I (we), as a responsible party understand that I, (we), owe the difference.

I (we) further understand that Central Alabama Radiation Oncology may utilize the services of a collection agency to expedite collection of any balance due. If such action becomes necessary, I (we) agree to pay all collection cost incurred by Central Alabama Radiation Oncology, including my attorney fees.

_____ _____

Patient Signature **Date**

FOR MEDICARE PATIENT ONLY

STATE TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER

(EXTENDED PAYMENT REQUEST FOR PHYSICIAN SERVICES APPLICABLE TO CURRENT AND FUTURE TREATMENTS)

Patient Name: _____ **Medicare Number:** _____

I certify that all information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Central Alabama Radiation Oncology.

I authorize Central Alabama Radiation Oncology and any holder of medical and billing information about me to release to the Health Care Financing Administration and its agents, any information needed to determine benefits payable for services rendered or the benefits payable for related services. I recognize that this authorization will permit Central Alabama Radiation Oncology to submit any Medicare claim without obtaining any additional signature from me, and will remain in the files of Central Alabama Radiation Oncology for inspection by the Medicare Carrier, and will continue in full force and effect unless cancelled by my written request.

_____ _____

Patient Signature **Date**