



## Financial Policy Information

We are please you have chosen Florida Oncology Tavares for your patient services.

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have put together this financial policy sheet.

**Commercial Insurance:** Florida Oncology Tavares will bill insurance provided that your carrier will make payment directly to our office. In the even your insurance company does not pay for billed services, the balance will be your responsibility. We will verify the insurance coverage and let you what, if any, percentage you will be responsible to pay. Payment is due on the date of service. **Please notify us of any changes in insurance coverage prior to time of service.**

**Medicare & Medicaid:** Please be advised that all Medicare/Medicaid claims will be filed through our billing agency. Our doctors are participating physicians and accept Medicare assignment. This means that Medicare will send a check to our office for payment of services rendered. As a courtesy to you, we will submit the co-insurance to your secondary carrier if Medicare had not already done so. These payment deductions will be seen in your monthly statements. If you do not have a secondary carrier, please be advised that Medicare requires us to collect the yearly deductible and the 20% balance on all allowed charges by law.

**Insurance Release:** I authorize Florida Oncology Tavares to release to my insurance company and to communicate with hospitals and other medical providers any required information regarding services provided including; medical, psychiatric, laboratory studies, HIV testing, and other medical data related to my care. I authorize any insurer or payer to make payment directly to Florida Oncology Tavares. A photocopy of this authorization shall be considered as effective and valid for the duration of this claim.

**Financial Agreement:** I understand that my insurance contract is between me and my insurance company. I also agree that I am responsible for any charges that my insurance company will not cover. Our front desk staff will ask you for payment for any past due balances as well as your portion of the payment for today's service. This includes co-pays, co-insurances and deductibles. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

**Out-of-Network & Self-Paying Patients:** As a service to you, we would like to meet with you so that we can arrange a payment plan that would be comfortable for both you and our office. We will be happy to discuss any questions that you might have.

We accept cash, personal check, VISA, MasterCard, Discover, and American Express credit cards. There is a \$40.00 service charge for returned checks.

Thank you for your cooperation. We hope this has answered any questions.

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Print Patient Name

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Date of Birth

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Signature of Patient, Parent or Legal Guardian/Representative

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Date