UHO
Upstate Hematology Oncology
at Community Care Physicians, P.C.

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A Touch of Healing

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Acknowledgement of Courtesy Insurance Billing Program

We are able to bill your insurance directly and save you the paperwork. We need the following authorization from you in order for this to work correctly.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE, AND HEREBY AGREE TO PAY AS SPECIFIED BELOW.

We will submit your claims for services provided by UHO to your insurance company.

1. We expect full payment from your insurance company within ninety (90) days of the date of service. If your insurance denies or fails to pay for our services you will be billed. Your account balance remains your responsibility.
2. Under our Courtesy Insurance Billing Program, we will ask your insurance company to pay us directly; however, some insurance companies may pay the patient instead. If this occurs, you should sign the check over to UHO and mail it with the insurance company's explanation of benefits and the stub from the monthly statement that you will receive from us.
3. You must notify us IMMEDIATELY of any changes occurring with your insurance company (i.e. change of coverage, change of billing address, etc…), as well as any address or phone number changes pertaining to yourself.
4. You will continue to receive a monthly statement until payment in full is received from you and/or your insurance company.

I have read the above Courtesy Insurance Billing Program information, and understand all aspects of the program. I understand that I will be responsible for any amount not paid by my insurance company. I also understand that I am responsible for any co-pays, co-insurance, deductibles, out of pocket, and non-covered services.

____________________________ ____________________
Patient Signature/Legal Guardian Date

____
Print Name

____________________________ ____________________
Financial Counselor Date