

MONMOUTH HEMATOLOGY ONCOLOGY ASSOCIATES, P.A.

100 State Highway 36 Suite 1B
West Long Branch, New Jersey 07764

PATIENT FINANCIAL OBLIGATION AND AGREEMENT

As a managed care provider and a participant in many insurance plans, we are happy and willing to accept your insurance. However, as you are aware, patients have deductibles and coinsurance fees (i.e. out of pocket expenses, the percentage of the contracted fees that you are obligated to pay according to your insurance plan). As a result of your deductible or coinsurance fees, we often receive a significantly reduced payment from the insurance company, because the amount that we have billed is used to satisfy your deductible and coinsurance fees.

To keep our office financially stable, as we continue to accept your managed care and insurance plan, we need to ensure that we receive proper payment for our services. Therefore, the following procedure will be put in effect immediately for all of our patients:

1. A credit card number, expiration date, and authorized signature will be kept confidentially on file in our office.
2. After services are rendered, your insurance company will be billed accordingly.
3. Monmouth Hematology-Oncology Associates (MHOA) will receive from your insurance provider a check and an Explanation of Benefits (EOB).
4. You will receive a copy of your Explanation of Benefits from your insurance carrier that will clearly indicate the amount paid to MHOA, and the amount of our charges that was applied to satisfy your deductible or coinsurance fees.
5. All payments that we were entitled to receive, but instead went to satisfy your deductible and/or your coinsurance fees, will be charged to your credit card account.
6. If charging your credit card becomes necessary, a receipt will be forwarded to you promptly.
7. This will not compromise your ability to dispute a charge, or question your insurance company's determination of payment.
8. If you have any questions about this policy, do not hesitate to ask us.

I have read this Patient Financial Obligation and Agreement, and agree to its terms.

Patient Printed Name

Patient Signature

Date

MONMOUTH HEMATOLOGY ONCOLOGY ASSOCIATES, P.A.

100 State Highway 36 Suite 1B
West Long Branch, New Jersey 07764

PATIENT FINANCIAL OBLIGATION AND AGREEMENT

MC VISA AMEX

Credit Card Number

Expiration Date

Name on Credit Card

I, _____ hereby agree to allow MHOA to bill the above named credit card for any outstanding balance not covered by my Insurance Company.

I understand that my credit card number will be treated with confidentiality in accordance with HIPPA guidelines and will not be used for any other purposes.

Patient Printed Name

Patient Signature

Date

PATIENT FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

I acknowledge that payment for services and supplies normally are due in full at the time services are rendered. In consideration for the Provider not requiring me to pay all charges for care and services rendered during my visit at the time of delivery, I hereby assign to Provider any and all rights to receive insurance benefits otherwise payable to me for products or services provided by Provider to the extent payable. I understand that my signature requests that payment by my insurance carrier be made directly to Provider. I authorize Provider to appeal denied insurance authorization and/or benefits on my behalf. I agree to cooperate with the requests of the Provider for assistance in efforts made by the Provider with its efforts to assist me in filing and collecting claims for coverage.

If my insurance carrier does not accept an assignment of benefits, I understand that all correspondence and payments to Provider may be sent directly to me. I agree that when and if any such payments are received, I will hold them in trust for Provider and promptly and immediately transmit them to the Provider for payment of my bill.

I acknowledge that this assignment of benefits in no way absolves me from financial responsibility for ensuring that the Provider is promptly paid in full for all charges for care, services and supplies regardless of the availability or lack of insurance coverage for such charges. I am responsible for the deductible, co-insurance, referrals and non-covered service as well as any other charges not promptly paid by my insurance carrier. I agree that I will be financially responsible for and promptly pay the provider for any claim or portion of claim thereof, due to Provider for supplies and/or services not covered by my insurance policy as of the date that care, service or supply was rendered. If my insurance company denies coverage or within 45 days of billing by the Provider has failed to pay for all or any billed charge, I will promptly pay the Provider for the full amount of any such charges. If my insurance coverage changes, I will promptly notify the Provider. In Medicare assigned cases, Provider agrees to accept the charge determination of the Medicare carrier as the full charge for services and supplies that are covered by Medicare to the extent required by Medicare.

I understand that Provider has a legal obligation to seek payment from me for co-insurance and co-payment amounts owed and that this agreement supersedes and will prevail over any other agreement to the contrary. Any modifications, deletions, or changes to this form are void and will not be honored.

I certify that I am the patient or the patient’s duly authorized representative and that the information given by me to Provider in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I understand, acknowledge and agree to the terms set forth above.

Patient Name (please print)

Date

Patient Signature

IF YOU HAVE A COPAY PLEASE BE PREPARED TO PAY IT AT EACH VISIT BEFORE BEING SEEN BY THE PHYSICIAN OR NURSE.

YOU ARE RESPONSIBLE FOR OBTAINING REFERRALS FROM YOUR PRIMARY CARE PHYSICIAN AND ALSO MAKING SURE YOUR REFERRAL IS UP TO DATE IN ORDER TO BE SEEN BY THE PHYSICIAN OR HAVE TREATMENT.