CAROLINA SURGERY & CANCER CENTER, PLLC

advanced personal care close to home

CAROLINA SURGERY & CANCER CENTER - 1501 TATE BLVD SE, SUITE 202 - HICKORY, NC
TELEPHONE 828-485-2707 FAX 828-485-2708

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have implemented the following financial policy. If you have any questions please feel free to discuss this with our staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. For your convenience we accept VISA , MasterCard and Discover.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans that we have an agreement with and will collect any required copayments at the time of service. The copayments will be collected when you arrive for your appointment. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of the statement.

If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

We will also bill your health plan for all services that we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

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Signature: (Patient or Legal Guardian of Minor Child) Date