

CARSON TAHOE RADIATION ONCOLOGY ASSOCIATES

Diplomates, American Board of Radiology

Billing Address: P.O. Box 21300 Reno, Nevada 89515-1300

Dear Patient:

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatments needed to restore your health. If you have any questions or concerns about our payment policies, please do not hesitate to call our business office. The following is our Financial Policy.

We ask that all patients read and sign our Financial Policy as well as complete a Patient Information Form on your first visit.

Payment for services can be made in several different ways. We accept CASH, CHECKS or CREDIT CARD payments. We will process your insurance claim for our reimbursement if you provide us with the necessary insurance information.

Please inform our business office of any insurance changes, address changes and telephone changes.

1. Your insurance policy is a contract between you, your employer and the insurance company. We ARE NOT parties to that contract. Our relationship is with you, the patient, not your insurance company. However, we will bill your insurance company as a courtesy to you.
2. All charges are YOUR responsibility whether your insurance company pays or not. Most services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover, or cover at a lesser percentage.
3. Medicare patients without a secondary insurance and patients who do not have insurance will be asked to make partial payments at time of service.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our business office so that we can assist you in the management of your account. If a payment plan is needed or any other assistance required, please feel free to call our business office.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and welcome the opportunity to serve you.

Patient Signature _____

Date _____

Medical Billing Representative: Beth

(775)689-9217

Medical Billing Representative: Valyre

(775)689-9219

01/08/2015