HUDSON VALLEY HEMATOLOGY ONCOLOGY ASSOCIATES, RLLP

REFERRAL, COPAYMENTS, PATIENT RESPONSBILITY and OFFICE POLICIES

REFERRALS

If your insurance company requires that you obtain a referral in advance of your visit, it is **your responsibility** to make sure you bring the referral with you or have it sent to us prior to your visit or get the referral number from your referring MD. We regret that we cannot call for you (emergency cases only).

DATE: ______________ OFFICE LOCATION:_________________ Patient Account Number_______________________

Patient Name: ____Contact #__________________________________

INSURANCE PLAN: ______________________________________ID#_______________________________________

Referring MD/PCP:_______________________________________MD telephone______________________________

COPAYMENTS, COINSURANCES and other out of pocket expense

All copayments and other expenses are due at the time of service. If you are having a treatment, HVHOA will require a deposit at the time of service based on the information we received from you insurance company. If we have to bill for a copayment, you will be charged an additional $5.00 to cover our billing expense.

AFFORDABLE CARE PLANS – Individual plans

Any patient who has a monthly premium due for an individual plan **must bring proof of payment for that month** at the time of visit.

BOUNCED CHECK POLICY

HVHOA accepts checks as payment but if you bounce one check, you will be charged a 50.00 bounced check fee and we not be able to accept checks from you in the future. We will only accept cash, credit card or bank check.

MISSED APPOINTMENTS

It is the patient responsibility to cancel your appointments at least 24 hour in advance.

PATIENT AUTHORIZATION

I understand that if my health insurance company requires that I obtain a **REFERRAL** from my **Primary Care Physician (PCP)** prior to receiving medical services or treatment. If I do not provide Hudson Valley Hematology Oncology Associates with a referral as required by my insurance company, **I AGREE TO BE PERSONALLY AND FINANCIALLY REPSONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED** and to be treated as an out of network patient and **responsible for payment at the time of service.**

By signing this form I understand the referral, copayment, deductible and office policies of the practice.

SIGNED: ____DATE:___________________________________

PRINT NAME: ____

WITNESS: ____DATE: __________________________________

WITNESS PRINT NAME: ____

***This form is valid for ONE YEAR. Front Desk employee must witness and sign this form.