Thank you for choosing **Americare Kidney Institute** to meet your special needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, of which we require that you read and sign on the attached.

Our billing department is staffed with knowledgeable associates that are available to discuss any questions that you may have regarding your insurance or your account **Monday through Friday 8:00am – 5:00pm @ (440) 799-4224.**

Co-payments, outstanding balance and any financial arrangements made prior to your appointment are due when you check-in for your visit. For your convenience, we accept Cash, Checks, Money Orders, Visa, MasterCard, American Express & Discover credit and debit cards.

INITIAL ________

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REGARDING INSURANCE: Your insurance policy is a contract between you and the insurance company. We do work diligently to participate with most insurance companies that serve our local communities. A current patient information sheet with assignment of benefits must be filled out and signed. We will require that this be updated annually or as needed. We will copy all insurance cards: front and back side. We will bill your insurance plan(s) for you, as long as you provide to us the correct information. Please be aware that some, and perhaps all of the services provided may be non-covered services and/or not considered medically necessary *under your health insurance plan*. You, as the patient, are ultimately responsible for payment of all services provided by our facilities. All copayments are required at the time of service. If you have secondary and third insurance, we will bill it for you, as a courtesy, as long as you have provided us with the appropriate information.

INITIAL _______________

REFERRAL FORMS: If you are covered by an insurance company that requires referrals, it is **imperative** for **you** to contact your Primary Care Physician (PCP) and have their office make a referral to us **prior to** your appointment. If your plan requires a referral to obtain **your full benefits** and you incur an out-of-pocket penalty by not supplying one, you will be responsible for the non-covered amounts connected to that visit.

INITIAL _______________

MEDICAID PATIENTS: You are not responsible for any balances due after Medicaid has paid unless your Medicaid plan has a "spend down." In order to know that you have Medicaid, you must present your Medicaid Card at **EVERY** appointment.

INITIAL _______________

SELF-PAY PATIENTS: If you are not covered by medical insurance, you will need to speak to the billing office by calling (440) 799-4224. It is **imperative** that you speak to a billing representative who may be able to offer you additional information including a minimum deposit for services provided during your visit. Help is available so you may be asked to complete financial forms to document qualification guidelines.

INITIAL _______________

DELINQUENT ACCOUNTS: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 90 days. We realize it may be necessary, on occasion, to arrange installment or other payment plans. If you are facing a financial hardship, you may be asked to complete financial forms if necessary to document qualification guidelines for financial assistance.

INITIAL _______________

If financial problems arise, please do not hesitate to contact our billing department as soon as possible. Communication is key in helping you.

COLLECTION ACCOUNTS: You will be responsible for any legal, interest, and/or collections costs incurred if your account is assigned to collections. We have the right to purse any legal methods in collecting monies owed. Once an account is turned over to a collection agency we may require you to transfer your care to another provider.

INITIAL _______________

RETURNED CHECKS: If a check is returned by the banking system for any reason, you will be required to pay the amount of the check plus a returned check fee of $30.00 within 14 working days of the returned check notice by cash, money order or debit/credit card. If payment is not received within that time your account will be placed in collection status and you will be required to pay cash prior to any future appointments being scheduled.

INITIAL _______________

Payment plans are accepted. For more information, contact our billing department.

Please let us know if you have any questions or concerns.

I have read and received a copy of this Financial Policy. By my signature, I understand and agree to Americare Kidney Institute, LLC financial policy.

_______________________________________ _______________
Signature of Patient or Responsible Party Date

_______________________________________ _______________
Witness Date