Advanced
NEPHROLOGY ASSOCIATES, PC
SPECIALIZING IN NEPHROLOGY AND HYPERTENSION

Office Financial Policy

Dear Patient,

We would like to share the following policy with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Patients are required to pay their CO-PAYS at the time of service.

If you are covered by Medicare, we will submit all charges for services rendered to Medicare and any applicable supplemental insurance plans. Any remaining balance after all insurance payments have been received is the responsibility of the patient and will be billed accordingly.

For non-Medicare patients who have insurance coverage with commercial insurance carriers, please note the following:
a) We will submit your claims for services rendered to all applicable insurance carries. In the event that the claims are denied by the insurance carrier, the patient is responsible for the charges and will be billed accordingly. Payment is due thirty days after receipt of your billing statement.
b) Any remaining balance after all applicable insurance carriers have paid is the responsibility of the patient and you will be billed accordingly. Payment is due thirty days after receipt of your billing statement.

Patients that do not have insurance coverage at the time of service will be responsible for the following
a) A new patient is required to pay a minimum of $100 at the time of service.
b) An established patient is required to pay a minimum of $50 at the time of service.

NOTE: If you are unable to pay the amount required at the time of service, payments arrangements must be made with the practice billing manager prior to the appointment. The remainder of the charge will be billed to the patient within thirty days of the appointment date. Payment in full is expected unless arrangements are set up by the billing department.

Patients that are applying for Medicaid are expected to contact our office with the information needed to submit claims (e.g. policy number) as soon as their application is approved. If this information is not received within sixty days of the date of service, the patient is responsible for all charges and will be billed accordingly unless other arrangements are made.

Patients will receive two courtesy statements if unable to pay at the time of service however; each additional statement may have a $5.00 charge added for preparation and postage fees.
A $25 fee may be charged each time a patient No Shows for an appointment. If you wish to reschedule your appointment you must do so 24 hours prior to your appoint time.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient Signature:_____ _____**Date** ____/____/____

Office Witness: _____ _____**Date**: ___/____/____