

# LAS VEGAS CANCER CENTER

## Financial agreement

Thank you for choosing Las Vegas Cancer Center. The following is our financial policy, which will help you with your concerns regarding our billing and payments.

Payment for services is due at the time of service is rendered. We accept cash, money orders. We also accept debit cards, Master card, and Visa with a 3% convenience fee. We will submit an insurance claim on your behalf. If your carrier is not contracted with our practice, the balance is then your responsibility to pay within 30 days of your first billing statement. **IF YOU HAVE A CO-PAY, DEDUCTIBLE OR OUT OF POCKET, IT WILL BE COLLECTED AT THE TIME OF SERVICE.**

You are responsible for knowing your insurance benefits. What are covered services in your plan? Do you require a PCP referral? You are responsible for obtaining your referral.

Any billed balances are due within 30 days of the statement date. Please have your insurance card and picture I.D. available for photocopying. Any changes in insurance, address, phone number or emergency contact information should be reported immediately.

Remember insurance authorization/referrals for services **DOES NOT GUARANTEE PAYMENT.** If your insurance does not pay in full within 60 days, we ask that you contact them as charges will be transferred to you. There will be a \$35 fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the cost of collection and or legal fees.

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I do hereby authorize release of information necessary to file a claim with my insurance company. I request that the payment for services rendered by Las Vegas Cancer Center be made on my behalf to Las Vegas Cancer Center. A copy of this signature is valid as the original. I understand that in the event my insurance does not pay for these services. I will be financially responsible. I have read the above policy. I agree and understand.

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Printed Name of Patient/Responsible Party

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Signature of Patient/Responsible Party

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Patient Date of Birth

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Date