KIDNEY & HYPERTENSION CLINIC OF ALASKA

Financial Policy

Patient Name: _____ Date of Birth: _____

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, all patients must complete prior to any treatment in our clinic.

- Payment is due at the time of service.
- We accept cash, checks, Visa, MasterCard, American Express and Discover.
- There is a $35 service charge on all returned checks.
- We offer a reasonable payment plan, upon request.
- There is a $50 fee for any appointments missed or cancelled/rescheduled within 24 business hours of original appointment.
- If you miss 3 or more appointments in a 12 month period, you may not be allowed to schedule appointments.

Regarding Insurance

- It is our goal to provide fast and efficient billing. It is your responsibility to provide us with complete, accurate, and timely insurance information, and to inform us of any changes.
- Please have your insurance card at every visit in the event it may be required.
- All deductibles and co-pays are due and payable at the time of treatment.
- Knowledge of your deductible, co-pays, and plan benefits is your responsibility.
- As a courtesy, we bill most insurance plans on your behalf. You authorize the clinic to release any information to process your claims, and for insurance benefits to be paid directly to KHCA.
- Please note, we are not an 'In Network Provider' for all insurances. It is your responsibility to verify and work with your insurance carrier. Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Please be aware that you are responsible for any charges not covered by your insurance for any reason.

Usual and Customary Rates

Our Practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our specialty in our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have any question or concerns. **I have read, understand and agree to this Financial Policy:**

_____ _____

Signature of Patient or Patient Representative **Date**

Provider Use Only

Form will expire on: _____ Staff Initials: _____ Date: _____