ADVANCED KIDNEY CARE OF CENTRAL FLORIDA

3175 Citrus Tower Blvd Clermont, FL 34711 PH: (352) 240-3812 | FAX: (888) 716-2003
131 Webb Dr, Suite C Davenport, FL 33837 PH: (863) 226-4676 | FAX: (888) 716-2003

FINANCIAL POLICY

Thank you for choosing Advanced Kidney Care of Central FL (AKCCF), PA for your medical needs. The following patient financial responsibilities and policies have been established to assist us in providing the highest quality of medical care.

Insurance:
It is your responsibility to know and understand your coverage and benefits. As a courtesy, we will file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security name, and relationship to the patient to file all claims. Patients are responsible for all fees at the time of service that are not covered by insurance, including co-payments, coinsurance, deductibles, and non-covered services or items received. **At every visit, please make sure you have all insurance card(s) and photo ID as well as any other forms that may assist us in processing your claim correctly.**

No Insurance:
If you are not covered at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. We ask that you pay at least 50% of the charges at the time of service. The remainder of this balance must be paid in 3 equal monthly payments. Cash, check, or credit card is accepted.

Worker's Compensation:
Worker's compensation will be filed if the patient notifies AKCCF upon scheduling an appointment and supplies billing information upon check-in. Details of the accident will be required and verified with your employer.

Returned Check:
There will be a $30 charge assessed for any check returned by your bank for any reason.

Past Due Balances:
Accounts that are not paid within 60 days from the date of service may be sent to our inhouse collections department. A collection fee may be added to the balance. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Medical Records:
If you request a copy of your medical records, you will be required to (1) sign a medical record release form and (2) pay a medical record fee prior to having your records copied. Please allow up to 7 days for this request to be processed.

Upon your written request, AKCCF will copy your medical record for the purpose of transferring your care to another provider or for your personal use. The fee for copies of your medical record is $1.00/page for 0-10 pages, $0.50/page for pages 11-50, and $0.25/page for pages 51 and up.

All request for medical records from an attorney, insurance company, or any other outside source will be charged $20.00 labor fee. There will be no charge for pages 0-10. Pages 11-50 will be charged $0.50/page and pages 51 and up will be $0.25/page.

Cancellation/No Show Policy:
We understand there may be times when you miss an appointment due to emergencies. We urge you to call 24 hours prior to canceling your appointment so another patient may utilize this time.

You may be dismissed from the practice after 3 or more no shows in a 12 month period.

Service Charges:
If 60 days after billing, you fail to pay any balance due on your account or fail to honor your established financial agreement, your account is subject to $5.00/month rebilling fee and/or may be sent to a collection agency. Handling charge up to 50% of your account balance if it must be sent to collection.
A fee of $30 will be assessed to your account for any check returned by your bank for any reason.

Billing Questions:
We outsource out medical billing to Practice Management. Please call (800) 395-7780 with any billing questions.

Dismissal Process:
There are several reasons that a person may be dismissed from our practice. A few reasons are as follows:

* Failure to keep scheduled appointments
* Being verbally or physically abusive to staff
* Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within 30 days of the date of the letter, one of our providers will be available for advice. After the 30 days, you will no longer be seen at our practice by any provider. A copy of your medical record may be forwarded to your new doctor after a formal request is made and applicable fees (if any) are paid.

I have read the Financial Policy. I understand my financial responsibilities and agree to the terms of this Policy.

_____
Patient Name

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Person Signing on Behalf of Patient (Print) Relationship to Patient

_____ _____
Witness Signature Date