Patient Name:_____DOB:_____Chart #:_____

Patient Financial Policy

Thank you for choosing Columbia Nephrology Associates, P.A. as your health care provider. We are committed to providing you with the best treatment available. We will bill your insurance as a courtesy to you with a copy of your current insurance card. If we do not have your insurance card, full payment is due at the time of service. If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility.

Method of Payment: We accept Cash, Checks, Money Orders, Visa, MasterCard, Discover, and American Express.

When Payment is Due: Payment is due at time of service in the office. Payments for billed balances can be made in our office at your next visit or by calling the billing office at (803) 567-5600. Our billing office is available to discuss any questions you may have regarding your insurance or account at Columbia Nephrology.

Medicare: We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance we will bill it for you. Any remaining balance will be your responsibility and billed to you.

Medicaid: We will bill your claims to SC Medicaid only. You are responsible for the $3.30 office visit copay at time of service.

HMO/PPO/Commercial: All co-pays are due at the time of service, we are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan. You are responsible for referrals, payment of all deductibles and co-payments/co-insurance, procedures without authorization, non-covered charges as determined by your contract with your insurance carrier. All payments are due at time of service. If there is no referral, you will be asked to sign a waiver and you will be responsible for the charges in full at time of service.

Self-Pay: Patients who do not have health insurance are responsible for payment of charges at time of service. If you are unable to make full payments, please contact our Billing Office at (803) 567-5600.

Past Due Account Balances: If your account becomes delinquent, Columbia Nephrology, will take the necessary steps to collect the amount due. We use an outside collection agency to assist in follow up on these accounts. To avoid any action on your account, please contact our Billing Office at (803) 567-5600.

Returned Checks: The fee for any returned checks is $30.00. This fee will automatically be added to your account when the check is returned by the bank. You will be asked to bring cash, money order, or credit/debit card to cover the amount of the returned check plus the $30.00 fee and you may lose your check writing privileges.

Lab Patients: According to the type of labs drawn or insurance coverage, you may be billed for your lab test by Quest and/or Columbia Nephrology. In this case you will receive a separate bill from Quest for the lab tests. Ask the front desk staff for any information on billing your labs.

Transplant Patients: Patients are eligible for Medicare for 36 months from the date of the transplant. After this period, Medicare terminates unless you qualify for some other reason such as disability or age.

Dialysis Patients: If our physician recommends that you begin dialysis treatment, please call our office at (803) 252-9907 to request Yolanda Welbon, our Financial Coordinator for guidance on your insurance coverage, Medicare eligibility, and your financial responsibility.

Hospitalizations: If you are hospitalized and see our physicians, you may have coinsurance, deductibles, and other balances due once your insurance has paid. We will bill you at that point and if unable to pay in full, please call our Billing Office at (803) 567-5600 to make payment arrangements.

I have read, understand, and agree to abide by its guidelines the payment policy regarding my financial responsibility to Columbia Nephrology, for providing medical services to me or the above named patient. I certify that the information I provide to Columbia Nephrology is, to the best of my knowledge, current, true, and accurate.

X Patient Signature_____Date_____

Guarantor Signature_____Date_____

(If guarantor is not the patient)

Consent for Treatment

By signing below, I, (or my authorized representative on my behalf) authorize Columbia Nephrology Associates, P.A. and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries.

I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

X Patient Signature_____Date_____

Authorized Representative Signature_____Date_____