



221 N Oak Ave,  
Cookeville, TN 38501  
Phone # (931) 646-0880

## Financial Policy

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our Patient Information Sheets before seeing the doctor.

Unless previous arrangements have been made, all payments are due at the time of the appointment. Payment may be made by CASH, CHECK, VISA OR MASTERCARD. We only bill insurance carriers with whom we participate (have signed an agreement with).

### Regarding Managed Care Insurance with which we participate:

You are responsible to supply our staff with your primary and secondary insurance identification cards(s) at the time of your appointment. If your insurance company requires a referral from your primary doctor, you must also present this to our receptionist prior to being seen, as we cannot bill your insurance without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full. If your insurance requires a copay, it must be paid at the time of the appointment.

### Regarding Non-Participating Insurances:

If we do not participate with your insurance, the bill is your responsibility and is due at the time of service. We accept CASH, CHECK, MASTERCARD and VISA. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

### Return Check Fee - \$30:

Our bank charges us a fee for any check that is returned for "insufficient funds" and this will be added to the patient's bill if this occurs.

**If you are unable to keep a scheduled appointment, 24 hours notice of cancellation is required. Otherwise a \$35 charge will be made for the time that was reserved to you.**

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. **Accounts that go to collection will be subject to a 25% charge.**

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns, please feel free to ask. If you cannot pay in full at the time of service, please let us know before you see the doctor. We are happy to work out a payment plan.

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I have read the above Cumberland Kidney Specialists' Financial Policy. I understand and agree to abide by its terms.

Name:

*(Please Print)*

Date:

Sign: \_\_\_\_\_