Norfolk Center for Cancer Care & Hematology

Dear Patient,

Before you begin treatment at our facility you must review with your insurance carrier how you and your insurance company will pay the charges for treatment provided by our facility and physicians. It is very important that you are aware of what your insurance benefits are. It is your responsibility to ensure that all of our charges are paid in full. Please understand that if any of our charges that are not paid by your insurance carrier are your sole responsibility to pay and that those payments must be made **at the time of the service. Copays are expected at time of service.**

Please sign below acknowledging that you have read this letter and understand your responsibility and obligation to pay **in full** any outstanding charges not paid by insurance, copays/calendar year deductible and without limitation, any self-pay balances.

In the event that any of our charges become the responsibility of an estate, you understand and agree that such an estate is obligated to pay in full any of your outstanding charges as well.

If you have any questions or concerns please feel free to contact us at (781) 410-9199.

Thank you for your assistance in this matter.

I have read and understand this letter and hereby acknowledge that I will pay for any outstanding charges not paid by my insurance including any self- pay balances.

Patient signature_____ Date_____

Patient Name_____

Witness _____ Date_____

Sincerely,

Billing Account Manager

Copy given to patient

1073 Pleasant Street, Brockton, Ma. 02301 Telephone (508) 427-5599 Fax (508) 427-9349