Karmanos CANCER INSTITUTE | McLaren FLINT

Medical Oncology Department
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PATIENT FINANCIAL AGREEMENT

I, _____ understand that my insurance company may or may not cover my total bill for treatment. If and when this occurs, I understand that it is my responsibility to cover the outstanding balance. I will then contact my carrier for any questions regarding my contract with my carrier.

If my insurance changes during my treatment, I understand that my new carrier may not continue to cover and I will be responsible for payment.

I understand the policy to be that, payment is due at the time of service, this includes, but is not limited to, co-payments under-insured or not insured. If payment is not made within 60 days, may account will be sent to collections, unless arrangements have been made.

_____ _____

Signature Date

_____ _____

Witness Date