SOUTHEAST KANSAS HEALTHCARE
1505 W. 4th
Coffeyville, KS 67337
(620) 251-2400 FAX (620) 251-1619

STATEMENT OF FINANCIAL POLICY

Southeast Kansas Healthcare is a provider for many insurance plans and will be listed in your group's provider list if we are participating in your plan. It is your responsibility to check with your insurance carrier to see if our clinicians are on your PPO or HMO. We will bill your insurance directly and receive payment directly from them. However, to avoid any confusion, be aware that we do expect payment of any applicable deductibles, co-payments or co-insurance amounts at the time of service. All services that your insurance will not cover are your responsibility also. We ask that you provide us with your current insurance information and update us when changes occur.

If we are not a participating provider for your insurance plan, we will still bill your insurance directly if you have provided us with complete information to do so. You may receive a statement for the entire charge prior to your insurance paying or you may be asked to pay in full at time of service because some insurance companies reimburse the patient directly instead of us. If you do receive a statement, we expect payment within 30 days.

Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact our business office at 620-251-2400 ext. 11 to make payment arrangements.

If you do not have insurance, payment is expected at the time of service. We accept Visa, MasterCard, and Discover for your convenience. There will be a $38.00 service charge for all returned checks.

Business Office hours are 8:00a– 4:30p Monday thru Friday. If you reach our voice mail, please leave a detailed message and we will return you call as soon as possible.

Thank you for choosing Southeast Kansas Healthcare as your provider!

I have read and understand Southeast Kansas Healthcares financial and claims filing policies.

Print Patient Name_____

Patient Signature_____Date_____

Responsible Party Signature_____