

East Tennessee Cancer and Blood Center

Dr. A.K. Sen, M.D., M.R.C.P. (U.K.) F.A.C.P.

*1406 Tusculum Blvd., Suite 2000
Greeneville, Tn 37745
423- 787-7080/423- 787-7087*

*110 Corporate Drive, Suite 120
Johnson City, TN 37604
423-282-0534/423-282-2064*

DATE: _____

Account Number: _____

Account Name: _____

I, _____ certify that I have been informed of the following policy:

**East Tennessee Cancer & Blood Center, LLC will only bill
Your secondary insurance one time after your Primary Insurance
has finished paying on the bill. Should your secondary insurance
Not pay or pay incorrectly, you will be held responsible for the
Co-Insurance as determined by your Primary Insurance.**

**If payment is not received with in thirty (30) days, this account
Will be subjected to a 1.5% interest rate. After ninety (90) days of
No payment, on the bill, it will be turned over to an outside
collection agency for the full amount due plus cost of collection
agency (40%), interest and court cost if this last step has to be
taken.**

PLEASE FOLLOW-UP WITH YOUR INSURANCE COMPANIES.

Patient/Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Cc: File, Patient, Insurance Clerk