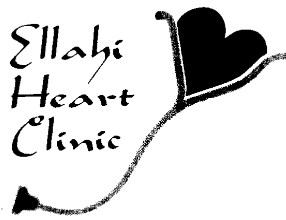

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Interventional Cardiology
Cardiovascular Diseases

FINANCIAL POLICY AND CONSENT FORM

Welcome to our office. We are glad you have selected our office to help with aspect of your medical care. So that we can better assist you we have outlined our policies about insurances, finances and payment below.
We sincerely want to make your visit with us a pleasant experience and will try our best to do so. By making our policies clear we hope to avoid any problems or misunderstandings. Please let us know if you have any question about your medical care, our policies or need further details.

Initials____ **Financial Responsibility:** As a courtesy, we will file our charges for you with your health insurance carrier(s). Unpaid balances after insurance has processed claims will automatically become your responsibly. A statement will be mailed to you and payment is expected upon receipt. Your health insurance is a contract between you and your insurance company. Coverage cannot be guaranteed. Misunderstanding about insurance can be avoided if you understand what your policy provides. Should your acct be turned over to collections you will be responsible for all attorney fees, court cost and any other fees incurred. In addition if I default in payment of my account, and you place this balance with a 3rd party collection agency for collection, I agree to pay add on collection charges in the amount of 10%up to 33.33% of the unpaid balance. I understand in the event of default you or your agents may list my unpaid balance as a collection account on my consumer credit report.

Initials____ **Deductibles, Co-insurance, and Co-pays:** Unless specific prior arrangements have been made payment of deductibles and co-pays, including those associated with Medicare and Medicaid will be expected at the front desk at the time of your visit.

Initials____ **Insurance Plans Requiring Referrals:** If you're insurance carrier requires you to have a referral prior to your seeing a specialist, our office must have received the referral before your arrival. If we do not have it upon you signing in your appointment will be rescheduled or full payment must be made prior to the office visit.

Initials____ **Non-Covered Charges:** We want to provide you with the best healthcare that we can possibly deliver; however, we find that occasionally there are certain service/devices that your doctor may prescribe as necessary that may be not covered by some insurance carriers. Until your insurance has submitted payment to us, we have no guarantee of any payment from the carrier. You will be responsible for checking coverage and any charges incurred. You will need to contact your insurance carrier with any problems concerning their payment to us.

Initials____ **Returned Checks:** There is a $35.00 charge for all returned checks. After check has been returned twice NSF, Payment to our office will be on cash basis only.

Initials____ **Outpatient Procedures Ordered**: Patients are financially responsible for any outpatient procedures ordered by the physician. Our office will assist in obtaining proper authorizations for the procedure indicated by your carrier prior to the date and time. You, the insured are ultimately responsible for what your coverage requires and we suggest that you contact your insurance carrier to verify your benefits & pre-authorization requirements prior to having the procedure done. Our office will not be responsible for your charges.

Initials____ **Prescriptions**: Our office requires 5 day notice when requesting any medication refills. No refills are approved after hours or weekends**! It is the patient's responsibility to provide a current list of all medications currently taking at the time of every appointment.**

Date: ___/___/____