



PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with the business office. We are dedicated to providing the best possible care and regard your complete understanding as an essential element of your care and treatment.

PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience we accept VISA and MasterCard, as well as checks and cash

INSURANCE

If you are a member of an insurance plan with which we participate, we will file your primary insurance for you. We don't bill 3rd party insurance. At the time of service, your responsibility will be the authorized co-payment, deductible, and/or co-insurance. You will receive a statement for any additional amounts your insurance company deems your responsibility after processing its claim. Should your insurance delay payment for more than 120 days, you may be held responsible for full payment of the amount charged. Please check with the office staff to verify our participation with your particular insurance company or plan.

If you have insurance coverage with a plan for which we do not have a contract agreement, you will be considered a self pay patient or your out-of-network benefits may apply to your visit. If you are a self-pay patient, charges for your treatment will be totally your responsibility and due at the time of service. If you have out-of-network benefits, your insurance will pay at a lower percentage and deductibles will apply. You will be responsible for any deductible and co-insurance at the time of service. If you wish for us to file your insurance, we will, providing you supply us with ALL necessary information. You will also need to provide us with a signed authorization enabling direct payment to our office. You will be refunded any amount paid by your insurance within 30 days from the date payment is received. All insurance coverage is a matter between you and your insurance company, and you are ultimately responsible for payment.

REFERRALS/AUTHORIZATIONS

If you have a policy with a Health Maintenance Organization (HMO, MC, POS or EPO), it is your responsibility to obtain a referral from your primary care physician for your visits.

NUCLEAR STRESS TESTS

Radioisotopes used to perform nuclear stress tests are ordered for individual patients 24 hours before the scheduled test date. If you are unable to keep an appointment for a nuclear stress test, please cancel the appointment within 24 hours.

RETURNED CHECKS

A service charge of \$25.00 will be charged for any returned checks.

I have read and understand the financial policy and I agree to be bound by its terms. By signing below, I assume full responsibility for any balance owed after my insurance plan has paid. (NOTE: Even if you refuse to sign this form and you elect to receive services-You are still 100% responsible for any fees.)

Patient's Name (PRINT) _____

Patient's Signature _____

Date _____