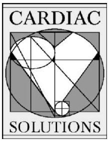

PATIENT FINANCIAL POLICY

Thank you for choosing Cardiac Solutions as your health care provider. We are committed to building a successful physician-patient relationship with you. Your complete understanding of our patient financial policy is important to our professional relationship. If you have any questions regarding our financial policy, please discuss with our Business Office.

Payments

All co-payments, co-insurances, deductibles and balance on accounts are due at time of check-in. Payments can be made with cash, personal check and credit cards. We accept Visa, Mastercard, Discover and American Express.

Self-Pay

Payments are required in full at the time of service.

Out of Pocket Expense

Payments will be collected prior to any procedures or testing that is deemed your responsibility by your Insurance plan.

Insurance

We will bill your primary and secondary insurance. In order to properly bill your insurance plan, we require that you disclose all information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide necessary information will result in patient responsibility for entire bill.

Once your insurance plan has processed and paid for services rendered, we will bill you for what your insurance plan determines is your responsibility for services. Your insurance plan determines your co-pays, deductibles, co-insurance and coverage. With all the varieties of insurance plans and policies, we ask that you please be familiar with your plan and benefits. The term of your insurance policy is between you and your insurance company.

Should your insurance plan delay payment due to documentation requested from you for services already rendered, we will allow no more than 60 days from date of service then you will be held financially responsible. HealthCare Providers are required by insurance plans to file claims in a timely manner or be denied. It is crucial you respond to any questionnaires you receive from your insurance plan.

If your insurance plan is not contracted with us and claims are processed out-of-network or denied you will be responsible for charges not covered.

We do not bill any third-party liability insurance (auto, homeowner).

Please visit Cardiac Solutions website at www.cardicasolutions.net for participating insurances.

Revised [12/2019]

Referrals and Authorization

With the variety of Health Plans requiring a mandatory referral/or authorization, we will initiate the request to your Primary Care Physician (PCP). We ask that you confirm with your PCP a referral/or authorization has been sent to us. If no referral is received per your plan requirement, we will need to re-schedule your appointment.

Outstanding Balance Policy

It is our office policy that all past due accounts be paid in full, unless previous arrangements have been made with our Business Office. If payment is not made or you have not made payment arrangements to resolve your account balance, you stand a chance that your appointment will be re-scheduled. If there is no resolution to resolve your balance, it may be sent to outside collection agency.

Miscellaneous Charges

Returned Checks: A service charge of $25.00 will be applied to your account in addition to the insufficient fund amount.

Completion of Forms: Our fee for completing any type of form (s) is $25.00 and is required to be paid prior to completion.

Cancellations of Nuclear Stress Test

Radioisotopes used to perform nuclear stress test 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 call and cancel appointment within 24 hours.

Out-of- Pocket Maximum- (If Applicable)

If your out-of- pocket max is met for calendar year, you will need to provide documentation from your insurance that shows out-of-pocket limit has been met for the year.

I have read and understand the patient 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________________________

Revised [12/2019]