

## **FINANCIAL POLICY**

Thank you for choosing us as your cardiology health provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we provide as pertinent information prior to any treatment.

### ***IF YOU HAVE INSURANCE***

We cannot send a claim to your insurance carrier unless you provide us with the information, which THEY require. Please give your card(s) to our receptionist. You must also be aware that some or all of the service we provide may not be covered in full or in part by your insurance carrier.

***In these cases, reimbursement for services is YOUR responsibility.***

***CO-PAYS are payable prior to seeing your physician.***

### ***IF YOU HAVE MEDICARE - PART B COVERAGE –***

Medicare Part B pays only for services that are determined to be reasonable and necessary under Section 1862(a)(1) of Title XVIII of the Social Security Act. If a particular service is not reasonable and necessary under Medicare standards, although it would otherwise be covered, Medicare Part B denies payment for that Service. If we feel that such a situation may exist, you will be given a responsibility form to sign. Without this agreement signed, we will not be able to perform the procedure. Our receptionist will discuss this further with you, if it is necessary.

PLEASE be aware that we are required by Medicare to collect deductibles from you, in event that you do not have secondary insurance coverage. Please furnish your Medicare card and the card for the secondary carrier, if you have this coverage, to our receptionist.

### ***IF YOU DO NOT HAVE INSURANCE –***

Payment in full at time of service is expected, unless you have made advance arrangements with our business office. If you have not, please inform the receptionist that you would like to speak to a counselor.

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**WE WILL INITIATE COLLECTION ACTIVITY AT THE TIME THE BALANCE DUE FROM YOU REACHES 90 DAYS IF NO ARRANGEMENTS HAVE BEEN MADE WITH US.**

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I HAVE READ THE ABOVE FINANCIAL POLICY. I UNDERSTAND THIS POLICY AND AGREE TO IT.

\_\_\_\_\_  
Signature of patient or responsible party

DATE \_\_\_\_\_