ADVANCED CARDIOVASCULAR CENTER

For: ..... Date of Birth: .....

..... MRN: .....

Financial Policy and Patient Responsibility

We are committed to providing our patients with the highest quality care.
Thank you for taking the time to read and understand our policy.

Healthcare Providers and Patients have a unique relationship with insurance carriers and different sets of responsibilities.

It is the **Patient's** Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage prior to their appointment regarding such items as contracted physicians with their plan, covered and non-covered benefits, authorization requirements, deductibles, coinsurance, and co-pays. We recommend you contact your carrier directly with any questions pertaining to your coverage.
- To obtain a referral from their Primary Care Physician (PCP) prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-pay, deductible and coinsurance at the time of service when requested.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To pay any balance due as a result of non-disclosure of any health insurance coverage.
- To facilitate claims payment by contacting their insurance carrier when claims have not been paid.
- To understand that as a courtesy, we will file claims with a secondary or tertiary insurance carrier one time. Payment and/or follow up on balances due by a secondary or tertiary insurance are the patient's responsibility.
- To be held responsible for any return check fees.
- **To cancel an appointment at least 24 hours in advance. Failure to give a 24-hour time notice may result in the assessment of a no-show fee: $25 for an office visit, $50 for testing.**
- To pay a $25 administrative fee or to make an appointment with the provider, when requested by the provider, for the completion of forms such as FMLA, Disability and other forms requiring manual completion. Payment is required in advance and is not billable to your insurance carrier.

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It is the **Provider's** Responsibility:

- To file insurance claims on the patient's behalf. We will file a claim with primary carriers. As a courtesy to our patients, secondary and tertiary claims will also be filed one time. A 60-day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.
- We are not responsible for providing insurance coverage and benefit information to patients. As a courtesy, our Billing Department is available to assist you with your questions.

I authorize the release of all medical information that is pertinent to my medical care and necessary to process my insurance claims. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Advanced Cardiovascular Center LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for all charges. In the unfortunate event that an account is given to a collection agency or to an attorney, for collection, then the patient/responsible party shall pay to Advanced Cardiovascular Center LLC all costs of collection, including reasonable attorney's fees and court costs, in addition to other amounts due Advanced Cardiovascular Center LLC. I have read this information and agree with this policy.

I have read and understand the PRIVACY PRACTICES, AUTHORIZATION FOR RELEASE OF

MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT contained herein.

Advanced Cardiovascular Center LLC may release any information regarding my medical condition and treatment to my insurance company. I assign all insurance benefits to Advanced Cardiovascular Center LLC. I understand I am responsible for any and all charges. I agree to pay any balance unpaid by my insurance company. This authorization will remain in effect until revoked by me in writing.

I have read and understand the above financial policy. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

Patient Name (please print):

Date: **Signature:**

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