

# CARDIOVASCULAR CONSULTANTS, INC. PS

## FINANCIAL AGREEMENT, EXTENSION OF CREDIT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for myself, shown by statement, promptly upon presentation thereof, unless credit arrangements are agreed upon.

In accordance with the Federal Truth-in-Lending Act; which requires us to give our patients information in connection with extension of credit, please be advised of the following policies, which apply in this clinic. The responsible party agrees:

1. To pay cost and/or reasonable attorney fees if any delinquent balance is placed with an agency or attorney for collection or suit.
2. **NSF FEES:** If a patient writes an NSF check (non-sufficient funds) or issues a stop payment, an administrative fee of \$26.00 will be added to the patient's account.
3. **NO SHOW FEES:** Because of the time allotted for each patient visit, those individuals who do not keep their appointments or do not cancel within 24 hours in advance will be subject to a no-show fee of \$50.00. Nuclear imaging appointments will be charged a \$300.00 no-show/cancellation fee.
4. **COPAYS:** We require any copayment **at the time of service**, otherwise you may be billed an additional \$25.00 copay billing fee.

About health insurance:

- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.
- IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR BENEFITS. THEREFORE, IF YOU HAVE QUESTIONS REGARDING YOUR BENEFITS, YOU SHOULD CONTACT YOUR CARRIER IMMEDIATELY.
- We will bill your insurance claim for you. If you have a secondary insurance, we will bill it one time only, as a courtesy, as long as you have provided us with the appropriate information. You will be responsible to re-bill this secondary insurance if that becomes necessary. If you bill any insurance yourself, please do so promptly, so that you will receive reimbursement before your account is considered delinquent. If you have a third insurance, it will be your responsibility to bill them.

**REFERRALS:** It is your responsibility to obtain the appropriate referral from your primary care physician. We will assist you with this if necessary; however, your appointment may have to be rescheduled if the appropriate referrals are not in place on the date of your appointment.

It is agreed that payment will not be delayed or withheld because of any insurance coverage or the pendency of claims thereof, and all proceeds of insurance are assigned to the office where applicable, but without their assuming responsibility for the collection thereof. A copy of the assignment is as valid as the original.

Accounts 30 days past due are subject to collection proceedings, except when prior arrangements have been made with our business office.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our Business Office as soon as possible by calling (253) 735-6083.

I authorized and request my insurance company to pay directly to Cardiovascular Consultants, Inc., PS., insurance benefits otherwise payable to me, for any services furnished to me by the listed provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

FOR YOUR CONVIENIENCE WE ACCEPT CASH, CHECKS, VISA & MASTERCARD.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_  
Please PRINT name