ADVANCED INTERVENTIONAL CARDIOLOGY CONSULTANTS

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OUR FINANCIAL POLICY

Patient' Name:_____ DOB:_____/_____/_____

Thank you for choosing Advanced Interventional Cardiology Consultants as your health care provider. We are committed to providing quality medical care. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. Please let us know if you have any questions.

- We will verify your insurance coverage at every visit. It is the patient's responsibility to supply the most current insurance card/s. If inaccurate or untimely information given to the staff results in denial or noncoverage by your insurance company, the guarantor will be responsible for payment.
- Full payment is due at the time of service.
- We accept cash, checks, Visa and MasterCard.
- A $25 fee will be charged for all returned checks.
- Payment plans must be arranged in advance with the Patient Accounts Department.
- HMO & PPO patients requiring referral authorizations must make sure we have received all authorizations and referrals prior to making arrangements for health care or testing.
- When labs or other tests are ordered by our providers, you are responsible to check with your insurance company as to where you are authorized to have these studies done. We will not be responsible for any bill if you have a test done at the wrong location.

As a courtesy to our patients, we will submit claims to your primary and secondary insurance carrier for you. Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. The patient is responsible to know the rules of their health plan.

I hereby authorize Advanced Interventional Cardiology Consultants to release any medical information required in the course of examination and treatment and permit payment directly to them for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage; this includes but is not limited to co-insurance, co-payment, deductible and non-covered services.

I have read, understood and agree to the Financial Policy (above).

_____ _____
Signature of Patient or Responsible Party Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices for Advanced Interventional Cardiology Consultants. I have read it in its entirety and have had the opportunity to ask any questions. I also understand that I have the option to request a copy.

_____ _____
Name of Patient or Responsible Party (Please print) Relationship to Patient

_____ _____
Signature of Patient or Responsible Party Date

MEDICARE AUTHORIZATIONS

I request that payment of authorized Medicare benefits be made on my behalf to Advanced Interventional Cardiology Consultants for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap (secondary insurance – if applicable) benefits be made on my behalf to Advanced Interventional Cardiology Consultants for any services furnished to me by their providers. I authorize any holder of Medicare information about me to release to my Medigap insurance carrier any information needed to determine these benefits payable for related services.

_____ _____
Signature of Patient or Responsible Party Date