CARDIOVASCULAR INSTITUTE OF SCOTTSDALE

Our Financial Policy

Our office will provide the highest quality of care to our patients while being considerate of the cost... Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any services rendered:

- ♥ We will bill contracted insurance companies as a courtesy... Your current insurance information is required for accurate billing. You (patient or responsible party) will be responsible for all co-payments, co-insurance, deductible plus any balance due on non-covered services from your plan. **Co-payments are due at the time of service.**
- ♥ If you **do not** have insurance, payment is expected at the time of service unless other arrangements have been made.
- ♥ Our staff will be happy to assist you with any questions you have, but we cannot be responsible for knowing or interpreting the benefits of each individual policy. All patients are responsible for knowing the requirements of their insurance plans, including in-network lab and radiology facilities. Patients are also responsible for knowing what services are covered by their plan and which services need a pre-authorization.
- ♥ **Please be advised that your coverage for testing performed in the office may differ from office visit benefits.**

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1. I have read the above statement and I understand that I am financially responsible for all co-payments, co-insurance, deductibles plus any balance due on non-covered services from my plan. I understand that all co-pays are due at the time of service.
2. I understand I am responsible for any services that my plan determines as “non-covered,” such as, but not limited to, preventative and/or routine services.
3. I understand that I will be billed a $25.00 service charge for all checks that are returned by the bank.
4. I understand that the office is not able to verify insurance benefits for every patient. I understand that I am responsible for understanding my plan’s benefits and for selecting a physician and/ or facility under my plan.
5. I agree to pay all the amounts owed and all expenses incurred in collecting any unpaid balance, including a 35% fee from the collection agency.
6. I understand that I may be charged a fee of $50.00 for any appointments cancelled without 24 hour advanced notice.
7. I understand there may be a charge of $75.00 if I request medical records sent to an insurance company, regarding disability, automotive or life, or records sent to an attorney or law firm. I also understand that a $50.00 fee will be applicable for completion of disability paperwork, FMLA or life insurance paperwork. I understand that each process may take up to 10 business days.
8. I understand that the office may request that I fill out demographic and insurance information every 6 months, even if there has been no change.
9. I authorize the release of medical information to my insurance company. I understand that if I do not authorize release, then payment will likely be denied or delayed by my insurance company. In this circumstance, I understand that I will be responsible for my bill.

By signing below, I acknowledge that I have read and understand the above policy.

Signature ________________________________ Date _______________________

Print Name ____