SPRINGFIELD CARDIOLOGY

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Financial Policy/Assignment of Benefits

Thank you for choosing us as your health care provider. We are committed to providing excellent health care services to you. As part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

***It is your responsibility to provide us with your most current insurance information**.

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim and you will be financially responsible for services rendered.
- Your insurance is a contract between you, your insurance and possibly your employer. It is your responsibility to understand the level of services covered by your insurance company. We may accept assignment of insurance after verification of your coverage and as a courtesy we will file an insurance claim for you. However, responsibility for payment by your insurance company rests with you. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance. **You are financially responsible for services not covered by your insurance company.**
- ***Co-payments are due at the time of service.*** If you fail to bring you co-payment your appointment may be rescheduled.
- If you do not have insurance, payment in full for all services will be due at the time of service. If you are unable to pay in full at time of service a payment plan may be agreed upon.

* **It is your responsibility to provide us with your most current billing information.**

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our office within 30 days after the receipt of the initial statement. A re-bill fee of $5.00 may be added to your balance for each additional monthly statement sent after the initial statement.
- Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- If you are unable to pay the balance in full, you must contact our billing office to discuss a payment plan. If you fail to make the agreed upon payments, your account may be referred to a professional collection agency. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance.
- We may charge a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- Failure to keep your account balance current may require us to cancel or reschedule future appointments.

*Financial responsibility for a minor rests with the adult accompanying the minor regardless of whose insurance covers the minor.

*We accept cash, check, money order, Discover, MasterCard, and Visa

I have read the financial policy as written above and understand and agree to this financial policy. I authorize payment of medical benefits to Springfield Cardiology (Taj Medical Inc,) and the release of any medical or other information necessary to process a claim for services rendered by Springfield Cardiology (Taj Medical Inc.)

_____ Date_____

Patient or Responsible Party Signature

_____ Patient Date of Birth: _____

Print Patient's Name and Date of Birth