Golden Empire Cardiology

Patient Financial Policy

Our practice is committed to providing our patient with the highest possible care. The following is a statement of our Financial Policy, which we require each of our patients to read, understand and sign prior to any treatment.

Cash Patient Policy
If you do not have a valid insurance plan to cover the costs of our services, you will **need to pay for your visit prior to receiving the service/ procedure**. Any payment arrangements requests should be made prior to seeing the doctor.

Medicare Patients
We accept Medicare assignment under the Medicare program. We will bill Medicare as a courtesy and you will be responsible for the annual deductible and the 20% of the allowable charges Medicare will not pay. Secondary insurance will be billed only if you provide us with the correct information. If there is no response from the insurance co. **within 30 days, the patient is responsible.**

Private Insurance Patients
Our billing department will bill your insurance as a courtesy. We find that some insurances only cover a portion of your expense. Patients are required to pay for the remaining portion. **We note that an insurance policy is a contract between the patient and the insurance company.** Our practice is not a party to that contract. Therefore, the patient is completely responsible for the cost of every treatment if and when the insurance fails to process and pay our claim **within 60 days.** We will bill your secondary insurance **one time**, and then it will be the patient's responsibility to collect payment from their secondary insurance thereafter.

Industrial Patients
Your worker's compensation carrier is responsible for your medical expenses. We require that complete billing information is provided and that **prior** procedure **authorization** is obtained to ensure medical treatment. You will, however, be responsible for payment of our charges should your workers compensation claim be determined "UNACCEPTABLE" by your employer or Worker's Compensation Carrier.

HMO Patients
Your co-pay is due at the time of service. You will be considered "cash patient" if your HMO fails to acknowledge your eligibility when they process our claim.

Copying of Records & Completion of Forms
We charge a fee of $25.00 for completion of forms and $25.00 for copying of medical records. Echocardiogram tape fee $25.00

Usual & Customary Rates
Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary. If your account becomes delinquent you may be sent to our outside collection agency. **All past due accounts will be assessed a $15.00 per month late fee if monthly payments are not received. We Now Accept VISA and MASTERCARD. If your check is returned you will be charged a $25.00 returned check fee. There is a surcharge fee of $15.00 if co-payment is not made at the time services are rendered.**

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician- patient relationship with this practice. Our physicians will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

COPAYMENTS, COINSURANCE, DEDUCTIBLES AND PATIENT BALANCES ARE DUE AT THE TIME OF YOUR VISIT REGARDLESS IF YOU HAVE RECEIVED A STATEMENT.

I have read the above and acknowledge that I am aware of the Office Financial Policy. I also agree failure on my part to comply with this policy will make my account eligible to be given to a collection agency.

Authorization for Insurance Benefits
I authorize Golden Empire Cardiology to bill my insurance company directly. Furthermore, I authorize my insurance company to pay the above provider the benefit accruing to be under my medical-hospital and surgical policy. I also authorize my insurance company and/or the above provider to release information regarding myself for services provided.

Patient Name _____

Date _____ / _____ / _____ Signature _____

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