Cardiology Specialists of Virginia PC

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FINANCIAL POLICIES

We welcome the opportunity to discuss any aspect of our Financial Policies with you or your legal/authorized representative. Please ask to speak with a representative from our Billing and Insurance Department.

Please verify with us, at the time of service, that we participate in your insurance plan. If your insurance requires a referral and/or authorization for our services it is **your** responsibility to obtain a valid referral and/or authorization prior to each appointment. **Without proper authorization, your visit will be rescheduled.**

PRIMARY INSURANCE: We will submit a claim to your primary insurer if you provide us with adequate information. SECONDARY INSURANCE: We will submit, as a courtesy, a claim to a secondary insurer (if you have one) if we have the necessary information, which includes the Explanation of Benefits (EOB) from your primary insurer.

NON-CONTRACTUAL INSURANCE & UN-INSURED PATIENTS: If you are covered by an insurer with whom we do not have a contract (primary and/or secondary), or if you are uninsured, you will need to speak with our Billing and Insurance staff prior to your appointment. Payment in full is expected prior to receiving our services. The Billing and Insurance staff can provide you with the exact charges for the specific service(s) for which you are scheduled, and can also provide a good faith estimate of the cost of typical services performed by our physicians and staff that may be required for your cardiovascular problem(s). They will gladly answer any questions that you might have.

ALL CO-PAYMENTS AND APPLICABLE DEDUCTIBLES ARE DUE AT THE TIME OF REGISTRATION, PRIOR TO SERVICES.

METHOD OF PAYMENT: We accept cash, personal checks, money orders and Credit/Debit cards under the Visa and MasterCard systems.

MISSED APPOINTMENT AND MISCELLANEOUS FEES: You will be charged a fee for: i) any appointment missed, or if you cancel with less than 24 hours prior notice; ii) returned checks or other payments refused or denied by a financial institution or credit/debit card provider; iii) completion of forms (e.g. life insurance, disability, etc.); iv) prescription refills, *if requested outside of an office appointment* (*no* charge for refills provided during an appointment); v) telephone consultations and/or discussions; vi) medical records copies if not specifically paid for by a third party. These fees are not covered by your insurance plan and you hereby accept personal responsibility for them and agree to pay them at the time of service.

BILLING STATEMENTS: Following any applicable insurance processing, you will be billed for any balance due on your account. Payment in full is due upon receipt. If additional billing statements are required to collect the balance due, a fee may be added for each additional statement sent.

RESPONSIBILITY FOR PAYMENT: In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to, health insurance deductibles, co-payments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

By signing below, I certify that I have read and understand the above, as well as the Fee Schedule provided to me, which is subject to change without prior notice. I have had the opportunity to ask questions and have them answered and I accept the above conditions and terms. I further certify that I am the patient named below or am the guardian, duly authorized representative, parent or other family member of the patient holding the authority to sign this document for the patient.

_____	_____	_____
Patient Name (please print)	Patient/Guarantor Signature	Date