SOUTHEAST CARDIOLOGY
Caring for the heart, from the heart

SOUTHEAST CARDIOLOGY FINANCIAL POLICY FORM

Thank you for selecting our office for your medical care. In order to prevent any misunderstandings concerning the responsibility for payment of medical and surgical services provided to our patients, the following is supplied: Please understand that our service agreement is with YOU and NOT your insurance company. You are responsible for payment for the service(s) rendered not covered by your chosen insurance company.

ASSIGNMENT OF BENEFITS For services received, I hereby authorize and direct that payment(s) be made directly to Southeast Cardiology for benefits payable under the terms of my policy. I recognize that if payment is made directly to me, the amount received, up to the amount due for services rendered, is the property of SE Cardiology Clinic and should be paid over to SE Cardiology Clinic immediately. I understand that I am financially responsible for charges not paid by this assignment.

MEDICARE We are participating providers of Medicare Part B only. Please remember that if you only have Medicare, the remaining 20% of the allowable fee plus the Medicare deductible (if not already met) is the patient's responsibility.

MEDICAID We are participating providers of Medicaid. If you are a Medicaid recipient, please provide us with your card to verify eligibility and your co-pay at the time of service, if applicable. If you have Medicaid coverage pending, we require payment for the services at the time of your visit. If it becomes retroactive and Medicaid pays for the services, we will refund your payments in coordination to what Medicaid has covered.

OTHER INSURANCES Co-payments for office visits are required at the time of arrival. After filing with your insurance, if a balance is put to your responsibility, prompt payment is required. Deductibles and co-insurance are due prior to surgery. Our Financial Director is here to help explain your financial responsibility. For your convenience, we are pleased to accept various forms of payment as well as offer financial lending assistance.

RETURNED CHECKS AND DELINQUENT ACCOUNTS There will be a $35.00 charge for all returned checks. If your account becomes delinquent and must be placed with a collection agency, you agree to accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs if such is necessary.

PRIOR CONSENT TO CONTACT BY CELL PHONE You agree, in order for us to service your account or collect monies you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages and/or emails. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

PERSONAL FORMS There will be a fee of $25 per form that must be paid prior to our office completing (ex: disability, FMLA, personal policy claims, etc.). We also ask that you give us 7-10 business days following the date of the procedure to complete these forms. Most forms cannot be completed until after surgery is performed and our physician has completed all associated notes.

*I have read and understand this policy and my financial responsibilities to Southeast Cardiology

Patient's Signature _____ DOB: _____

Patient's Social Security Number _____ Date: _____

If Minor - Adult's Acknowledgement: _____ Date: _____

If Minor - Adult's Social Security Number: _____