OUR FINANCIAL POLICY

Revision Date: December, 2009

Thank you for choosing Regional Cardiology Associates, PLC as your medical provider. We are committed to you and the success of your treatment. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our financial policy which we request that you read and sign prior to your visit.

- Full payment is expected at the time of service. Cash, Check, Visa, Master Card, and Discover are accepted.
- We are now able to ***authorize*** a credit card for future payment of your visit/testing. Your credit card is not charged until your insurance company notifies us of exactly what you owe. This saves us from sending you confusing statements at a later date. If you do not wish to utilize our new credit card authorization system, a $5.00 statement fee may be applied to your account.
- Please bring all your insurance information necessary for us to bill your insurance carrier. Patients with an HMO (HealthPlus, Blue Care Network, etc.) must have a referral from your primary physician. We will only accept assignment of benefits with insurance plans with which we participate. Any remaining balances (such as co-pays and deductibles or non-covered services) are your responsibility.
- The adult accompanying a minor (parent/guardian) is responsible for full payment unless we participate with your insurance plan. The adult accompanying the patient is responsible for any co-pays and deductibles.
- Any account with an account balance which has not had a payment made every month may be charged a billing fee.
- Any account over 100 days old without payment arrangements and monthly payment activity will be turned over to a collection agency.
- Failure to call and cancel/reschedule a **physician** appointment within 24-hours prior to the appointment time will result in a missed appointment fee of $45.00.
- Failure to call and cancel/reschedule a **testing** appointment within 24-hours prior to the appointment time will result in a missed appointment fee of $125.00.

Thank you for your understanding and for choosing us for your medical needs.

I have read and agreed to this financial policy as outlined.

Signature/Patient/Responsible Party: _____Date:_____

Witness: _____