The Heart Center Cardiology, PC

Financial Policy

Thank you for choosing The Heart Center Cardiology, PC as your cardiovascular specialty healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our staff will be available to discuss our fees and this policy with you. The services you have elected to participate in imply a financial responsibility on your part. We ask that all responsible parties read and sign our financial policy prior to seeing the physician. Payment for all services will be due at the time services are rendered. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf; however, you are ultimately responsible for the entire bill. As the responsible party, please understand:

1. Your insurance policy is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-pays, covered charges, second insurance and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.
2. Fees for services, which include unpaid balances, deductibles and co-pays and in some cases co-insurance, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.
3. All charges are your responsibility whether your insurance company pays or does not pay. If any payment is made directly to you for services billed by The Heart Center Cardiology, PC, you recognize an obligation to promptly remit payment to The Heart Center Cardiology.
4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by The Heart Center Cardiology, PC, I will be responsible for all costs of collecting monies owed, including collection agency fees.
5. The above does not apply for those patients that are considered Workers' Compensation. However, be advised that as a compensation patient you may be held responsible for charges in the event that your claim is denied or not paid or determined not to be work related.
6. We understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing.
7.

ASSIGNMENT OF BENEFITS: I/We, the undersigned authorized benefits from Medicare, Medicaid and all Commercial insurance companies be made on my behalf to The Heart Center Cardiology, PC for any services furnished to me.

AGREEMENT TO PAY: I/We, the undersigned, 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 be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:
I/We agree, in order for The Heart Center Cardiology, PC to service my account or to collect monies I may owe, The Heart Center Cardiology, PC and/or their agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. They may also contact me by sending text messages or emails, using any email address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure/financial policy and agree that The Heart Center Cardiology PC, its employees and/or agents may contact me/us as described above.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient: ___________________________________ Patient Date of Birth: ____________________

_________________________________ ___/___/______ _______________________________________

Signature of Patient or Responsible Party Date Relationship, if other than the patient

_________________________________ ___/___/______ _________

Signature of Witness Date Time