FLORIDA
CARDIOLOGY, P.A.

FINANCIAL POLICY

In compliance with the Federal Consumer Protection Act, Florida Cardiology, PA is furnishing you with information regarding their financial responsibilities.

Welcome! We are pleased you have chosen Florida Cardiology, PA for your specialty healthcare needs. We'd like to familiarize you with how our services are billed, which insurance claims we file on your behalf, when we request payment from you and our credit policies. It is our belief that the best service is possible when there is a mutual understanding between you and the physician. We ask that you take the time to read our policy so we can avoid any misunderstandings. If you have any questions our billing department will be happy to discuss them with you.

INSURANCE

Florida Cardiology participates in many PPO and HMO plans, as well as commercial insurance products and Medicare/Medicaid. All copays are due at the time services are rendered.

If you have an indemnity plan (80/20) and your deductible has been met we will file for you. You will be responsible for your 20% at the time services are rendered. If your deductible has not been met, payment in full is required at time of service.

Please direct questions to a billing representative.

NOTE: Even though we may participate in your insurance program, some charges may always be your responsibility. Your insurance company may require pre-authorization for office visits and/or procedures. I understand that if proper authorization is not obtained from my PCP (primary care physician) I will be liable for charges incurred. It is always your responsibility to understand the coverage your insurance program provides and its referral authorization process.

We will furnish you with a monthly statement of your account showing the amounts billed to you and any payments received on your account. This monthly billing will also provide you with a detailed aging of how long balances have been outstanding.

Payment can be made in cash or by check from a local bank. We also accept Master Card, Visa and American Express.

In cases of hardship we may agree to set up a payment schedule for patient balances due. All payment plans are arranged on a case by case basis. Please speak with a Manager or billing representative if payment arrangements are necessary.

COLLECTION POLICY

Payment for services which have been billed to you are due in full within 30 days of receipt of your billing statement. If you fail to pay within a reasonable amount of time or cooperate with the terms of an agreed upon payment schedule your account may be turned over to an outside agency for resolution.

NO SHOW FEE

Effective June 16, 2006 there will be a $25.00 fee assessed for no show appointments. No shows are appointments that are not cancelled with a 24 hour notice. With appropriate notice we are able to schedule other patients in a vacant time slot and to also decrease wait times, by not having to work-in emergent patients.

Work-in patients are patients that needs to be seen within 24 hours due to their symptoms. This is one reason why we cannot guarantee that you will be seen at your appointed time. Although we make every effort to see our patients within 30 minutes of the scheduled appointment time there are times when this is not possible due to work-in-patients, hospital emergencies, scheduled patients with complicated cases, etc.

Please assist us in our effort to maintain as smooth a patient flow as possible by canceling appointments 24 hours in advance.

I assign payment directly to Florida Cardiology, PA, the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment. I will assist in the collection of my insurance should there be a delay in payment. I agree to actively pursue collecting insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days the claim remains unpaid, I understand the balance will be due from me.

I understand that I am financially responsible for my/the patient's account with Florida Cardiology, PA, regardless of my insurance benefits.

I authorize a copy of this form to be valid as the original.

_____ _____

Patient Signature Date