FINANCIAL POLICY

Patient Name: ________________________________

Thank you for choosing **Advanced Cardiology of Texarkana** as your health care provider. So that we may continue to provide you with the best care available, we ask that you please adhere to the financial policies of the practice.

-Payment methods accepted: Cash, check, money order, Visa, MasterCard, American Express and Discover.
-Automatic draft may be set up on either the 5th or the 15th of each month.
(Please initial)

_____You may require an echocardiogram (ultrasound of your heart) that is not included in the cost of the office visit. Please be sure to talk with patient accounts regarding payment.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. If an insurance carrier has not paid within 60 days of service, professional fees owed to Advanced Cardiology of Texarkana will be patient's responsibility.

MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All co-payments or deductibles are due and payable at the time service is provided.

NON-COVERED SERVICES Any service not reimbursed by your insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

- **A fee not to exceed $30.00 will be collected prior to completing medical forms**.

MEDICARE PATIENTS: If you have Medicare only, there is a co-pay of$25.00 due at the time of service. Medicare covers only 80% of your charges therefore, the co-pay will be applied to the balance. I request payment of authorized Medicare benefits be made to Advanced Cardiology of Texarkana for any services provided. I authorize Advanced Cardiology of Texarkana to release any information necessary to secure payment.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical benefits to Advanced Cardiology of Texarkana. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Advanced Cardiology of Texarkana to release any information necessary to secure the payment.

I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature: ____ Date: _______