# FINANCIAL POLICY

Thank you for choosing CARDIOVASCULAR INTERVENTIONS, P.A. as your health care provider. Because of the many changes in insurance companies and the requirements of referrals / authorizations by Primary Care Physicians, we are requesting that our patients' sign this Financial Policy stating that their insurance company has not changed from the prior visit and that we have the correct insurance information.

It is also a requirement of your insurance plan to know where your Laboratory work will be sent. Please select the lab corresponding to your insurance plan.

☐ Quest Diagnostics ☐ Florida Pathology ☐ Labcorp ☐ Other:_____

**Participating HMO, PPO, POS and Indemnity plans:**

- Please understand that it is the patient's responsibility to understand the rules and regulations of their policy. If we are not a participating physician, you may be responsible for charges incurred.
- If applicable, please obtain required referral / authorization from your Primary Care Physician prior to your visit. You may be rescheduled if no authorization has been obtained.
- Please call your insurance company prior to your visit to make sure our physicians participate with your insurance plan and that your services are a "covered" benefit.
- If your insurance requires a co-pay, this will be collected at the time of your appointment.

We will file your insurance claims as a courtesy. If your claims have not been paid within a timely manner, you may receive our billing statement notifying you of these circumstances. At that time you will be asked to call your insurance carrier to check claim status first and then call our Billing Department at (407) 896-7899 to assist you.

**Self Pay and Non-Participating Insurance:**
All self-pay and non-participating insurance patients will be expected to have payment in full at their visit.

- Any and all past due patient balances will be collected before your appointment.
- Cancellations will need to be arranged 24 hours in advance.
- Returned checks are subject to a $25.00 service fee.
- Please inquire about fees for medical records and to complete various forms.
- This Financial Policy statement must be signed prior to any treatment.

*We thank you for your understanding.*
I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ Date: _____
Signature of Patient or Responsible Party

_____
Patient's name (printed)