Cardiovascular Medicine
Patient Financial and Electronic Communications
Policy

We would like to thank you for choosing Cardiovascular Medicine as your healthcare provider. Cardiovascular Medicine is committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For Our Patients with Medical Insurance:
Cardiovascular Medicine will gladly submit all claims to all carriers. We participate with many insurance plans, including Medicare. Plans change frequently so please contact our Patient Accounts Department or your insurance company to verify participation in your plan. Please bring your insurance card with you at the time of your appointment. It is your responsibility to provide us with your insurance information in a timely manner.

Co-Payments:
Your insurance requires us to collect all co-payments at the time of service. For your convenience we accept cash, checks, or the following credit cards: Visa, MasterCard, and Discover. If you do not pay your co-payment at the time of service, a $5.00 fee will be applied to your account.

Deductibles:
Many insurance policies require patients to pay a deductible. If possible, we will inform you of the appropriate amount you will owe, and make arrangements for payment of this amount at the time of service.

For Our Patients with No Medical Insurance:
If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit.

Payment Plans:
Patient balances not paid in full within 30-days will be placed on a payment plan. Patients unable to pay their balance in full within 30-days must contact our Patient Accounts Department to set up a payment plan. Failure to establish a payment plan could result in further collection actions from a third party.

Electronic Communications:
By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my healthcare provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, or other limited billing information. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, the limited protected health information (PHI) regarding my healthcare events as identified above. I consent to receiving multiple messages in the form of voice mail, text, and email per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail or answering system, if I am unavailable at the number provided by me.

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Patient Signature ***Date***