



**FINANCIAL POLICY AND AGREEMENT
SELF-PAY & HEALTH INSURANCE COVERAGE**

Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. Should you be a cash patient, we may not ask for full payment at the time of service, although you will remain responsible for the full payment of all fees for services provided. If you have health insurance and even if we bill your insurance company directly, you may be responsible for copayment, coinsurance, deductible, and noncovered amounts. For your convenience, our office accepts personal checks, credit cards, and cash, and when appropriate, can provide you with mutually agreed upon payment plan. Please read the following carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, and disallow procedure codes, and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" changes – the amount they are willing to cover. The insurance company usually reduces the actual reimbursement further by the individual policy's annual deductible, copayment or coinsurance.

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes that the insurance company will likely reduce, combine, or simply deny. This system in fact, has the insurance company determining our fees. If we have a contract with your insurance company, we writeoff the amount over the "reasonable and customary", and bill you for your coinsurance and deductible. If we do not have a contract with your insurance carrier, you are responsible for that amount as well as any deductible and coinsurance.

We are required by all insurance carriers to collect from patients any deductible and copayment or coinsurance amounts. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of NonSufficient Funds or your account is turned over to Collections, you will responsible for all related costs.

I have read and understand Pacific Coast Cardiology's financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Pacific Coast Cardiology.

In the event Pacific Coast Cardiology agrees to seek payment initially from my insurance company, I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize Pacific Coast Cardiology to release all information necessary to secure payment of benefits.

Patient Legal Name (please print clearly) _____

Patient Signature _____

Date _____