FINANCIAL POLICIES

We are committed to providing the best medical care. We are pleased to help you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- As a courtesy, we will process and file your insurance claims for services. Please be mindful that all insurances and benefits are not the same. We will bill for services that were rendered in the office and/or hospital.
- Co-payments, deductible and/or coinsurances are required at the time of service. If you are a self-pay patient, you are required to pay for all services up front.
- For services that are not covered by insurance, we require payment to be paid up front before services are rendered.
- Returned checks are subject to handling fee of $40
- No show fee of $40, which is not billable to insurance, will be charged for any appointment not cancelled with 24 hours' notice
- No show fee of $150 for nuclear stress test, $75 for Echo and $50 for ETT if not cancel within 24 hours of appointment time.
- Patient will be charge $10 per statement after the first statements has been mailed.
- Patient balances over 90 days with no payments will be turned over to a collection agency. There will be an additional $50 administrative fee and 40% collection fee, attorney and court fees add on to unpaid balance.
- Medical Records- Patient - $25 (copies), Disability forms - $75, FMLA- $50

Please remember, it is your responsibility that you provided the office with the correct insurance card. Your insurance is a contract between you and your employer and/or insurance company. Since you are the recipient of services, all charges are your responsibility from the date the services are provided. You are responsible for charges not covered by your insurance, and payment must be made within 30 days as soon as responsibility is determined.

I understand and accept that, regardless of my insurance status, I am responsible for prompt payment of all charges for medical care and other services provided by East Atlanta Cardiology.

Patient Name: _____Date: _____

Patient Signature: _____