Cardiovascular Associates of Staten Island, LLC

Financial Policy

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care and we want you to completely understand our financial policies. Please read the policy and sign below. A copy will be kept in your chart.

1. **Insurance.** We participate in most major insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. Keep in mind that your insurance policy is basically contracted between you and your insurance company. Patients without insurance are expected to pay in full at the time of service. We accept cash, checks and most major credit cards.
2. **Co-Insurance.** Your co-insurance, which includes co-payments and deductibles, will be billed to you after the claim is submitted to your insurance. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles can be considered fraud and will result in our termination of your policy by your carrier.
3. **Non-covered Services.** Not all insurance plans cover all services. In the event your insurance plan determines a service to be non-covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
4. **Proof of Insurance.** All patients must present a valid insurance card at every visit before seeing the doctor. If you do not provide insurance information at the time of service, you will be held financially responsible for all charges incurred.
5. **Claims Submission.** As a service to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance company does not pay the Practice within a reasonable time period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
6. **Billing and Statements.** Each month you will receive a monthly statement for outstanding balances not covered by your insurance. Payment is due and payable upon receipt. A $25 service charge will be assessed monthly on any unpaid balance.
7. **Non-payment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from the Practice. If this is to occur, you will be notified that you have 30 days to find alternative care. During that 30 day period, our physician will only be able to treat you on an emergency basis. In addition, you will be responsible for any and all court collection and/or attorney fees, etc. which will be applied to your unpaid balance.

I have read and understand the Practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the Practice from time to time.

_____	_____	_____
Signature	Print Name	Date