CROSS RIVER
CARDIOLOGY

Financial Policy

It is our policy to assist patients so that they may receive maximum benefits from their insurance provider. However, the ultimate responsibility of the medical bill lies with the patient. As a courtesy, Cross River Cardiology, PLLC will file patient insurance claims if the patient has active coverage. Co-payments are due at the time of the visit, for every visit. Any uninsured patient that cannot pay the fee for service in full or an insured patient that cannot pay their remaining balance will be asked to sign a financial agreement. When unable to pay at the time of service, arrangements should be made prior to any appointment or any services rendered. When a patient's case is pending or in the process of litigation or any court matter, the patient is ultimately responsible for the bill. Other fees may also include but are not limited to, Medical Records, Disability Forms, and $20 for missed appointments. If any scheduled payment under a financial agreement is turned over to collections, all written off amounts will be added back on the account before sending to collections. There is a $25 processing fee for returned checks and the patients account will be debited electronically for the amount of the check.

Patient's Signature_____Date_____

Authorization to Discuss My Healthcare

I,_____**,** hereby authorize **Cross River Cardiology,PLLC,** to discuss information concerning my health, treatment, billing, and/or insurance information:

_____Spouse NAME_____

_____Child/Children NAME_____

_____Other (Specified) NAME_____

_____Do NOT release any information to anyone. May we leave you voicemails? _____Yes _____No

This consent will be good for two (2) years from the date signed. I understand that I may terminate this consent at any time by giving written notice to Cross River Cardiology, PLLC. Any changes to this form will require a new consent form to be completed, signed and dated.

NAME:_____SIGNED_____
(Please Print)(Patient/Parent/Legal Guardian)

WITNESS:_____DATE_____

HIPPA Acknowledgement of Receipt of Notice of Privacy Practices

I,_____, was given a copy to read of the Cross River Cardiology HIPPA policy statement. i have the right to obtain a copy upon request.

NAME:_____DATE:_____