Pediatric Cardiology Care

FINANCIAL POLICY

Pediatric Cardiology Care (PCC) was founded on the belief of providing the highest quality cardiac care with a personal and tailored plan that addresses each individual and family in their own unique way. We are pleased to discuss our professional fees with you at any time. Your understanding of our financial policy is important to our professional relationship. We value our relationship with our patients and ask that you please contact our office with any questions regarding this financial policy.

REGARDING INSURANCE

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. If your insurance carrier does not remit payment within sixty (60) days of being billed, the balance will be due in full from you. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance carrier. Should your insurance carrier require detailed descriptions of services, please have them request it in writing.

Insurance is a contract between you and your company. PCC is not a party to your contract. We will not become involved in disputes between you and your insurance carrier regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your insurance carrier. Please plan to show your current insurance card at each visit.

UNACCOMPANIED MINORS

Minors must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE

PCC does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

In order to assist us in establishing your PCC financial account, we ask that you please provide us all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information. In addition, patients are required to satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered. We ask that you provide your insurance company and PCC with any additional information requested to complete the processing of claims filed on your behalf.

- In the event my insurance carrier deems a service to be "non-covered" I understand that I am personally responsible for payment.
- I have read and understand that I am personally responsible for payment on this account when services are rendered.
- I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurance carrier or payor of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release.
- Assignment: I hereby authorize payment directly to PCC or my Physician. Any changes in this authorization must be received in writing within thirty (30) days of the effective date noted below.

Patient's Name:	
Patient's Date of Birth:	
Guarantor's Name:	
Guarantor's Date of Birth:	
Relationship to Patient:	
Guarantor's Signature:	
Date Signed:	