PATIENT FINANCIAL POLICY

IMPORTANT: SIGN THIS FORM ONLY AFTER READING AND UNDERSTANDING ITS CONTENTS. Please read these policies carefully and sign below, indicating that you have read and understand the policies detailed within.

The billing policy of PREventClinic, Inc. has been instated to facilitate and simplify billing and the bill payment process. We have partnered with InstaMed, the leading healthcare payments network, to **securely save your credit, debit card or bank draft on file.** Your balance will be applied against your form of payment after your insurance benefits are fully applied. This will occur 2 weeks after receipt of Explanation of Benefits (EOB) from your insurer.

We do not accept cash.

It is the policy of PREventClinic, Inc. that payment is due at the time of service. A**ll patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit.** At the conclusion of your visits with us, you will be billed for any outstanding balances. If there is a credit after adjudication of your bill, you will be provided a refund promptly.

As a courtesy, PREventClinic verifies your benefits with your insurance company. *A quote of benefits is not a guarantee of benefits or payment.* **We highly recommend you also contact your insurance carrier and check into your coverage** for (cardiology/cardiovascular services). Do not assume that you will not owe anything if you have more than one insurance policy.

We do all the work for you. This billing policy eliminates the hassle of writing and mailing paper checks. It also eliminates the chance of your personal information being viewed or stolen.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that ***you are 100 percent responsible for all charges incurred***: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

I<u>nsurance Participation:</u>
We are a participating provider for most insurance carriers. Please call to confirm that we accept your insurance coverage. At this time, we do NOT accept Medicaid.

Uninsured Patients:
We welcome self-pay or uninsured patients. PREventClnic will provide care with payment amounting to 50% of estimated charges at the time of service, provided that your form of payment is secured on file. All remaining balances will be due 2 weeks from the date of service. This balance **MUST** be paid by to avoid fragmented care.

No-Show Policy (Updated March 2022):
There will be a **$100 charge for a first time** (established patients) no-show or regular appointment cancellation of l**ess than 24-hours and a $200 charge for procedures (i.e., ultrasound, echocardiogram, stress test). For new patients (or second occurrence for established patients), this fee is $150 for office appointments.**

This fee is the responsibility of the patient and cannot be filed with insurance companies. We are happy to reschedule your appointments, provided changes to your appointment are made with our office during regular business hours. Any late cancellations made with after-hours answering service will still incur the charge.

Paperwork Policy:
PREventClinic is happy to complete necessary paperwork (i.e., Family Medical Leave Act (FMLA); Short Term Disability applications) at no cost that the **patient furnishes at the time of *scheduled* office visits**, as long as undue time is not required to complete them. In the event that medical records review and/or substantial time is required to complete the paperwork, we will complete such forms within 5 business days of presentation for a nominal $20 fee. **This fee is the responsibility of the patient and cannot be filed with insurance companies.**

I have read the policies listed above. I hereby authorize payment directly to **PREvent**Clinic, Inc that are otherwise payable to me for services as described. I realize that I am required to pay for non-covered services.

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Signature Date