Patient Name: _____

Date of Birth: _____ MR#: _____

The Chattanooga Heart Institute

FINANCIAL POLICY

Our objective is to provide you with the highest quality healthcare in the most cost-effective manner. However, the ability of The Chattanooga Heart Institute to achieve this depends greatly on your understanding of our financial policy and of your financial responsibilities. If you have medical insurance, we will file a claim on your behalf. We do this as a courtesy to our patients and to honor agreements with insurers who have contracts with The Chattanooga Heart Institute.

Failure to keep appointments and short-notice cancellations/reschedules —- $50 charge

In order to provide the best possible care for all of our patients, there is a $50 charge to patients who do not show for their appointment or who cancel or reschedule within 24 hours of their appointment time. Those that don't keep an appointment delay the delivery of healthcare to other patients. We appreciate your cooperation in striving to keep every scheduled appointment.

Medicare Patients

As a participating provider of Medicare Part B (physician services), The Chattanooga Heart Institute will only collect your Medicare co-insurance, co-pays, and deductible, and any charges for services rendered but not covered by Medicare. These amounts due from you are expected at the time services are rendered. All other reimbursement will be received directly from Medicare.

NOTE: You will be informed of services not covered by Medicare prior to these services being rendered. Your signature upon the appropriate Medicare Waiver form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility for these services. If you have a Medicare product that requires a co-pay, you will be responsible for the co-pay at the time services are rendered.

Commercial Insurance Patients

Please remember that your insurance contract is between you and your insurer. If your insurance company pays only a portion of your claim or reduces benefits based on your contract, you are responsible for these balances. Referrals are the responsibility of the patient. Referral forms and insurance cards should be presented when you check in. If you change insurers between appointments, it is your responsibility to notify us of the new information prior to your appointment to ensure our acceptance of the new plan. By signing this form, you give us permission to move your credit balance on one visit to the amount due on a different visit without advanced notification.

Co-pays, deductibles, and co-insurance are due at time of service.

HMO/Managed Care Insurance Patients

Many HMO/Managed Care plans require a referral. If a referral is required, it is your responsibility to obtain the referral prior to each appointment. Unauthorized services will be the financial responsibility of the patient.

Co-pays, deductibles, and co-insurance are due at time of service.

Patients Balances

Balances are due at time of service. If special financial arrangements are deemed necessary, you are responsible for making these arrangements prior to services being rendered. **NOTE**: All balances that are a result of hospitalization or a procedure are due within 30 days from the date of your first statement. If you are unable to pay, you should contact the business office immediately to discuss your options. ***Failure to follow financial policy may result in discharge from the practice***.

Collection of Unpaid Accounts

If you have an outstanding balance over 90 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and additional legal action. You agree to reimburse the Practice for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs. Once an account is turned over to collections, a collection fee will be charged in the amount of 23% of the total outstanding account. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you.

I have read and understand the above financial policy.

_____ _____

Patient/Guarantor Signature **Date**