PENINSULA CARDIOLOGY ASSOCIATES, P.A.

Patient Financial Responsibility Form

Thank you for choosing Peninsula Cardiology Associates as your healthcare provider. We are honored by your selection and promise to provide you with the highest quality healthcare. To do that, we ask that you help us by reading the following and sign so that we know you are knowledgeable of our Patient Financial Policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of their treatment or care.
- Patient is responsible for knowing the terms of their insurance and for providing Peninsula Cardiology Associates with complete and accurate billing information including (but not limited to):
  - Most current and up to date insurance card
  - Authorization numbers
  - Referral forms
- The patient is responsible for providing us with the most correct and up to date insurance information, and will be responsible for any charges incurred if the information provided is not correct or up to date. To benefit the patient, a copy of the insurance card must be presented at each visit.
- If patient is uninsured, they are responsible for keeping up with payments, and will pay when service is rendered.
- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatments not covered by or deemed experimental or investigational by their insurance. The payment is due at the time of the service and for your benefit we accept cash, check and most credit cards.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Peninsula Cardiology Associates. These charges include (but are not limited to):
  - Returned checks
  - Missed appointments without 24 hours notice
  - Extensive phone consultation and/or after-hour phone calls/e-mail requiring diagnosis, treatment, or prescriptions
  - Copying and distribution of patient medical records
  - Extensive form completion
  - Costs associated with collection of patient balances including services charges and attorney's fees.

Patient Authorization

- With my signature below, I authorize Peninsula Cardiology Associates: the physicians, staff and hospitals associated with Peninsula Cardiology Associates to release medical and other information acquired in my examination/treatment to the necessary insurance companies, third party payers and/or other physicians/healthcare entities required to participate in my care. This information may include but is not limited to the diagnosis, evaluation and/or treatment for alcohol and/or drug abuse.
- With my signature below, I authorize the assignment of financial benefits directly to Peninsula Cardiology Associates and any associated healthcare entities for services rendered as allowable under standard third party contracts.
- With my signature below, I authorize Peninsula Cardiology Associates communication by mail, answering machine, and/or e-mail according to the information I have provided
- With my signature below, I authorize Peninsula Cardiology Associates to charge unpaid costs to the credit card provided. Accounts with no activity for 60 days or accounts that are defaulted on will be referred to a collection agency or attorney, and any costs incurred through those services will be my responsibility. I also understand that there may be additional costs not included in my initial estimated bill and that those costs are my responsibility as well. Finally, I understand I can make appointments only once my balance has been paid or payments are being made.

I have read, understand and agree to the provisions of the Patient Responsibility Form

Signature of Patient/Guardian _____ Date _____

Printed name of Patient/Guardian _____ Date of Birth _____

Wavier of Patient Authorization- I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Patient/Guardian _____ Date _____