Cardiovascular Consultants, P.C.
Diagnostic and Interventional Cardiology

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Dear Patient,

Thank you for choosing us as your health care provider. We are committed to providing the best possible treatment.

Please complete the enclosed Patient Information Form. We will need all insurance information: NAME OF COMPANY, ADDRESS, PHONE NUMBER, POLICY NUMBERS, and POLICYHOLDER'S NAME and DATE OF BIRTH.
If you need assistance completing this form, we will be happy to help you at the time of your office visit.

Please bring in all current Insurance cards at the time of your appointment. We will need to be notified of any changes in your insurance, your address and/or phone numbers whenever they occur.

THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY:

EACH INSURANCE CARRIER HAS SPECIFIC RULES THE PATIENT AND DOCTOR MUST FOLLOW. IF THE PATIENT FAILS TO FOLLOW THESE RULES, SUCH AS OBTAINING AUTHORIZATION FOR THE VISIT, IT MAY RESULT IN NON-PAYMENT FROM THE INSURANCE CARRIER, AND WILL BECOME THE PATIENT'S RESPONSIBILITY.

If office visits are not a benefit of your insurance contract, payment is appreciated at the time of your visit.

We charge what is usual and customary for our area. We accept assignment of insurance benefits from many different insurance companies. Check with us if you have any questions regarding your insurance company.

If your insurance company requires co-pays and/or deductibles, you will be responsible for payment at the time of service. If co-pays are not made a $5.00 statement processing fee will be applied.

In rare cases some services may not be covered by your policy and could be your responsibility. We suggest that you check with your insurance company before any test is performed.

You will be responsible for supplying our office with any necessary referral forms at the time of your visit.

If you have any questions or concerns please let us know.

I have read the financial policy. I understand and agree to its terms. I, hereby authorize my insurance benefits to be paid directly to Cardiovascular Consultants, P.C., realizing I am responsible to pay non-covered services and I authorize the release of pertinent medical information to my insurance carriers.

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE