

**SOUTHEAST CARDIOLOGY CLINIC, INC.**  
**PAYMENT POLICY**

- 1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is the patient's responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Co-payments and deductibles.** All co-payments must be paid at the time of service. Also, all coinsurance and deductible are due at time of service. Payment of these items is part of your contract with your insurance company. Failure on our part to pay co-payments, coinsurance, and deductibles can be considered breaking your financial agreement. Please help us in upholding the law by paying your co-payment at each visit.
- 3. Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of service.
- 4. Proof of Insurance.** All patients must complete our patient information form before seeing the doctor or nurse practitioner. We must obtain a copy of your drivers' license or other picture ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
- 5. Claims submission.** We will submit your claims to your insurance as a courtesy. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- 6. Coverage changes.** If your insurance changes, please notify us before your next appointment so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
- 7. Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members will be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period our physicians will only be able to treat you on an emergency basis.

I understand and accept responsibility for Southeast Cardiology Clinic, Inc.'s payment policies. I understand that while this consent is voluntary, if I refuse to sign this consent, Southeast Cardiology Clinic, Inc. can refuse to treat me. I understand this authorization can only be revoked in writing, and if I revoke my consent, such revocation will not affect any actions that Southeast Cardiology Clinic, Inc. took before receiving my revocation.

I hereby certify that the information given in applying for payment under Title XVII and/or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration, the State of Alabama, Georgia, or Florida or their intermediaries, carriers or agents any information needed to determine these benefits for related services.

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Signature of Patient or Patient's Representative

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Date

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Relationship of representative to patient