



MORRISTOWN CARDIOLOGY ASSOCIATES

973-267-3944
973-455-0399(fax)
182 South Street, Suite 5
Morristown, NJ 07960

Financial Policy

This is an agreement between Morristown Cardiology Associates, P.A., as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Morristown Cardiology Associates, P.A.,

By executing this agreement, you are agreeing to pay for all services received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show any outstanding bills that are the patient's responsibility.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days of the statement date.

Payment options if you have no insurance:

Payment must be made at the time of service. You may choose to pay by cash, check, or credit card on the day that treatment is rendered.

Payment options if you have insurance:

- A. **Copayments:** Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.
- B. **Deductible or out-of-pocket:** You may choose to pay your deductible or out-of-pocket portions at the time services are rendered by cash, check, or credit card or a statement will be provided after insurance processing.
- C. **Out of Network carriers:** If we do not participate in your health plan, payment is expected at the time of service. You may choose to pay by cash, check, or credit card. We will request your insurance carrier send their payment directly to you. It is the patient's responsibility to verify participation status with the insurance carrier prior to the visit in our office.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance and secondary insurance companies as a courtesy to you however; we will NOT bill secondary carriers for co-payments due from a primary plan. We will NOT bill tertiary insurance companies. Although we may estimate what your insurance company may pay, the insurance company makes the final determination of your eligibility. You agree to pay any portion of the charges deemed non-covered or not medically necessary by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or denial from the insurance company. You agree to be responsible for payment of your account regardless of referral status. You understand that referrals may be a part of your insurance contract and therefore, the patient is responsible for ensuring said referrals are in place prior to the date of service. If you appear for your visit and a referral is not in place, you will have the option of rescheduling your appointment OR providing payment in full at the time of service.

Re-billing Fee: As stated above, payment of statements is due upon receipt. If payment in full is not received within 30 days of the statement date, a re-billing fee of \$5 will be imposed for each subsequent statement printed.

Returned checks: There is a fee (currently \$25) for any checks returned by the bank.

THIS FINANCIAL POLICY IS CONTINUED ON THE REVERSE SIDE OF THIS PAGE

CONTINUED FROM FRONT PAGE

Missed appointment fee: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a \$75 fee for established physician appointments, \$150 for any test or new patient appointments and \$200 for any missed nuclear stress test appointment. Patients with three missed appointments may be asked to transfer their records to another doctor.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. We will be happy to arrange a reasonable payment plan with you. However if all efforts to obtain payment on your account have been exhausted, your account may be forwarded to a collection agency. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees that we incur plus all court costs. In case of suit, you agree the venue shall be in Morris County, New Jersey.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Retrieval Fee: Copies of billing records are available without a fee for 30 days from the date of service or receipt of explanation of benefits. Any requests beyond this 30-day limit will require payment of a research fee (currently \$35 per hour). This fee is not reimbursable by insurance carriers and must be paid at the time of pick-up.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records (see Medical Records policy) . You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full. We cannot bill your attorney for charges incurred due to a worker's compensation case.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your auto carrier prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Coumadin Management: There is a monthly fee (currently \$25) for Coumadin or Warfarin medication management via telephone or fax. This charge is posted at the end of each month and is a monthly fee. You are NOT charged per telephone call or Protime.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____

Responsible party
(if not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____