

# Central Connecticut Cardiologists, LLC

## PAYMENT POLICY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **Payment is due at the time of service.**

**Insured patients:** Your insurance policy is a contract between you and your insurance company. We are a participating provider with many insurance plans and therefore accept assignment of benefits accordingly. Check with your insurance provider prior to your visit to be sure your policy is one with which Central Connecticut Cardiologists participates with. The co-payment is part of your contract with your insurer.

**CO-PAYMENTS, COINSURANCES AND/OR DEDUCTIBLE ARE YOUR RESPONSIBILITY AND WILL BE COLLECTED AT THE TIME OF SERVICE.** It is the patient's responsibility to know what services are covered by their policy. If a referral is required for your visit, please make sure that information is in our office the day before your visit, or your scheduled appointment may have to be changed. A copy of your current insurance card is required before services are rendered. Central Connecticut Cardiologists will file your insurance claim; all charges are the patient's responsibility.

**Non-Insured Patients: Payment is expected at the time of your visit.** If you cannot make payment in full, a minimum deposit of \$150 for office visits and for in office testing 50% of the charge is required prior to the service. This is a deposit and not the full amount that you will be responsible to pay. Payment arrangements for the balance must be made at the visit. Procedures such as cardiac catheterizations, pacemaker implants, or angioplasty/stent placement which are performed as an outpatient at the hospital require a 50% deposit. These procedures will not be booked until the deposit is received. Payment arrangements for the balance must be made with the billing office before the procedure is performed. Hospital charges involved with these procedures are billed by the hospital. You can make payment arrangements with the hospital.

**Payment Methods:** We accept most major credit cards except American Express, personal checks, or cash.

**Non-payment:** If your account is 90 days past due with no payment arrangements your account will be turned over to our collection agency. While we hesitate to do this, we will pursue monies owed to the practice. If a balance remains unpaid, you will be at risk of being discharged from the practice for failure to make an honest attempt at payment. If this does occur you will receive a certified letter indicating you have 30 days to find other medical care.

If you have any questions about the above information or any uncertainty regarding the participating status with your insurance policy, please call our billing office 860-525-4005. They are here to help you.

I understand the payment policy in full and agree to the financial responsibility for myself/dependents for all medical services rendered thereof:

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient