Lake Heart Specialists

Financial Policy

In order to achieve our goal of providing you with the best care possible, we need your assistance and understanding of our financial policy:

Financial:

- Your insurance coverage and benefits are a contract between you and your insurance company and, therefore, all disputes should be handled between you and your insurance company. Any questions regarding your insurance plan (including questions about your benefits, co-pay, deductible, or co-insurance amounts) should be directed to your insurance company.
- Please make sure you have a full understanding of your benefits and what patient responsibility may be if charges are not covered by your insurance plan. It is patient responsibility to know which services/procedures your insurance will and will not cover. Non-covered services will be patient responsibility.
- It is patient responsibility to obtain any referrals or authorizations required by your insurance plan PRIOR to services being rendered. If you do not have the required referral or authorization, your appointment may be rescheduled.
- It is patient responsibility for knowing if the physician you are seeing is in-network with your insurance plan.
- Any services provided by a lab or a hospital are a contract between the patient and that lab or hospital. Any dispute with that lab or hospital should be handled with them.
- If you are self-pay (do not have insurance), payment is due at the time of service.
- Any amount owed by you is due within 30 days of the initial statement.
- Any outstanding balance after 60 days may be turned over to an outside collection agency.
- Failure to pay balance may result in discharge from the practice.
- There will be a fee of $25 for any checks returned to our office. This amount will be added to your account balance.
- If you fail to make it to your appointment and do not notify us at least 24 hours in advance, you may be charged a $25 no-show fee.
- If you are scheduled for a Myoview stress test in our office and fail to notify us of cancellation within 24 hours, you will be charged $200.

By signing this document, I, _____, have fully read and understand the financial policy of Lake Heart Specialists.

_____
Printed Name of patient/responsible party

_____ _____/_____/_____
Signature of patient/responsible party Date