FLORIDA CARDIAC CONSULTANTS, INC.

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PATIENT FINANCIAL RESPONSIBILITY

- Payment in full is required at the time of service for all self-pay patients, insurance plans which pay patients directly, or for patients who have insurance plans where we are not participating providers.
- All co-pays are required at the time of service.
- Co-insurance and deductibles payments are required at the time of service.
- Your insurance is between you and your insurance company. You will need to familiarize yourself with the way your insurance plan works and how they pay. It is your responsibility to know if you need pre-authorization for testing, a specific laboratory that is to be used, or whether your insurance plan requires a referral. It may also be necessary for you to contact your primary care physician (PCP) should a referral be required. If you do not obtain a referral for a visit prior to your appointment, we may need to reschedule your appointment or the fee for services rendered may be your responsibility. Please contact your PCP to have them fax your referral directly to the office in which you will be seen prior to the date of your appointment. Our Sarasota office fax is 941-957-4248, and the Venice office fax is 941-483-9036.
- If your insurance company sends a check for payment directly to you, you are responsible for signing the check over to us for payment of services rendered.
- If you have a balance due after the insurance has paid your claim, you will be sent a statement itemizing the services rendered and the balance due. Your prompt payment is appreciated.
- Our business office will send claims to your primary and secondary insurances, however, proper billing requires that we have accurate information regarding your insurance. A copy of your insurance card(s) will be made at the time of your initial visit and stored in your electronic chart. If your insurance changes, please let the front desk know so that they can update your information.
- **If we do not have accurate information regarding your insurance, a referral from your PCP (if required), or pre-authorization for testing (if required) at the time services are rendered, the entire balance will be your responsibility.**

Patient Signature: _____ Date: _____

Printed Name: _____

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