COASTAL CARDIOVASCULAR CONSULTANTS, PA

459 Jack Martin Blvd
Brick, NJ 08724

1930 Hwy 35
Wall, NJ 07719

FINANCIAL POLICY

Participating Insurance Plans: We will submit a claim on your behalf for covered charges. You are responsible for deductibles, co-payments, coinsurance, items considered not "medically necessary," and any other non-covered services as determined by your insurance plan(s) for services rendered. Payment is due upon receipt of our statement.

Out of Network Insurance: Payment in full is expected at the time of service unless other arrangements have been made in advance.

Medicaid: We do not participate in the Medicaid program.

Referrals and Authorizations: It is your responsibility to obtain a valid referral and/or authorization prior to the time of service if your insurance plan requires one. If you wish to be provided with services for which you do not have a valid referral/authorization, you must pay in full at the time of service.

Copayments: Insurance copayments are expected at the time of service. If you do not pay your copayment, a fee of $5.00 will be charged to your account. This fee is not covered by insurance and is your personal responsibility.

Payment Options: We accept cash, personal check, and money order as payment. **We do not accept credit/debit cards.**

Returned Checks: There is a $10.00 fee in addition to our bank fee for checks returned as unpaid by your bank.

Past Due Accounts: Payment is due upon receipt of our statement. If payment in full is not made, a fee of $10.00 per statement cycle will be charged to your account. If a delinquent account is sent to a collection agency an additional fee of 50% of the balance due will be added to your account. There may be additional fees if court costs are assessed. These fees are not covered by insurance and are your personal responsibility.

Notification: For all issues concerning your account we will first attempt to contact you at the numbers you provided. If you do not respond we will attempt to contact you through the emergency contact you provided. You are responsible for notifying us promptly of any changes to your address, phone number, insurance, and/or emergency contact information.

Appointments: Time and resources have been specifically reserved for your office visit(s) and/or diagnostic test(s). There will be a charge of up to $150.00 if you fail to come in for a scheduled appointment or cancel/reschedule with less than 48 hours notice. This fee is not covered by insurance and is your personal responsibility.

Physician Phone Calls/Electronic Communication: There may be a $25.00 fee for return physician telephone and/or electronic communications requested between visits.

Form completion: There is a $100.00 fee for forms requiring completion by a physician without an office visit. This fee is not covered by insurance and is your personal responsibility.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company. It is your responsibility to comply with the terms of your insurance contract(s). Your doctor's bill for the services provided to you is an agreement between you and your doctor. You are personally liable for all balances not covered by your insurance.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

Release of Information: I authorize Coastal Cardiovascular Consultants, PA to release any information needed to determine benefits or benefits payable for related services.

Assignment of Benefits:
I authorize benefits be paid on my behalf to Coastal Cardiovascular Consultants, PA for services furnished to me by that provider.

I have read the Financial Policy and Authorization for Release of Information and Assignment of Benefits. I understand and agree to the above.

Print Name _____ Signature (SEAL) _____ Date _____