FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

- Payment is due at the time of service. This includes all *co-pays, deductibles and co-insurance*.
- If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.
- I understand that in the event I do not cancel my appointment within twenty-four hours of the scheduled appointment that the clinic may charge a cancellation fee.
- I authorize direct payment of my insurance benefits to Trident Heart and Vascular for services rendered to myself or dependents.
- Insurance will be filed for all services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance billing information.
- Out of Network services not paid by the health insurance company will be the responsibility of the patient or his/her guarantor.
- Trident Heart and Vascular or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.

Signature_____

Date_____

CONSENT TO CREDIT BUREAU INQUIRIES

I hereby consent to credit bureau inquires and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process I understand that these collection attempts could be performed by Trident Heart and Vascular or its affiliates/agents including, without limitation, any account management companies, independent contractors or collections agents.

Signature_____

Date_____

Lab / X-Ray / Diagnostic Services:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

Signature_____

Date_____

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION

& ASSIGNMENT OF BENEFITS

I consent to treatment necessary to the care which has been discussed and directed by the provider.

I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.

I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

I further authorize and request that insurance payments be directed to Trident Heart and Vascular

Signature_____

Date_____

PRIVACY PRACTICES:

Our office, physicians and staff, are committed to securing the privacy of your health by making available to you a copy of our Notices of Privacy Practices information.

Signature_____

Date_____