CAPITAL DISTRICT PEDIATRIC CARDIOLOGY ASSOCIATES, PC
PATIENT FINANCIAL POLICY AND RESPONSIBILITY FOR PAYMENT

PAYMENT OF CO-PAYMENT IS REQUIRED AT THE TIME OF SERVICE

Payment of applicable co-payment is required at the time services are rendered. For your convenience Capital District Pediatric Cardiology Associates, PC (CDPCA) accepts cash, personal checks and credit cards (VISA, Mastercard, American Express and Discover). Failure to pay your co-payment at the time of service may result in the rescheduling of your appointment. There is a $30 service charge for returned checks.

REFERRALS AND PRIOR AUTHORIZATION FOR OUT-OF NETWORK COVERAGE

If you are enrolled in a managed care plan, a referral from your primary care physician to a specialist may be required. The referral must be received by our office in order for your services to be covered under your insurance. Retroactive referrals are not allowed. If our office has not received the necessary referral prior to or at the time of service, your appointment may be rescheduled.

If CDPCA is an out-of-network provider for your insurance plan, it is your responsibility to obtain prior authorization to allow for in-network coverage for today's visit. Otherwise, your insurer may ask you for additional out-of-network fees, or claims made to your insurance may be denied. Even if your out-of network insurance allows for in-network coverage for your visit, additional charges to you may still be incurred.

INSURANCE

CDPCA is obligated to bill participating insurance companies. If CDPCA does not participate with your insurance company, we will still submit a claim on your behalf as a courtesy. In either case, you are expected to pay your co-payment at the time of service.

INSURANCE REIMBURSEMENT

Insurance reimbursement from participating insurances is forwarded by your insurance directly to CDPCA. If you have a non-participating insurance, you may receive insurance reimbursement payments directly to you from your insurer. If you receive such insurance payment, you are legally required to forward this reimbursement to CDPCA for payment of your bill.

FINANCIAL ASSISTANCE

CDPCA realizes that patients may have financial difficulties. If necessary, CDPCA can help you to set up payment arrangements with our billing office. CDPCA also has a financial hardship policy by which you may apply for a reduction of payments (other than co-payments) that are due.

RESPONSIBILITY FOR PAYMENT

If I am not currently enrolled in a health care plan, or if my health insurance is not accepted by CDPCA, or if there are services rendered by CDPCA that are not fully covered by my insurance (such as in high-deductible insurance plans or out-of-network claims), I agree to accept responsibility for full payment. If a required referral or prior authorization is not yet obtained for this visit, I understand that I may reschedule my appointment. If a referral or prior authorization is not produced but I elect to be seen today, I agree to be financially responsible for all charges incurred today. It is my responsibility to notify CDPCA of any changes to my insurance coverage prior to this visit or any future visits.

_____ _____

Name of Patient Patient Signature or Personal Representative

_____ _____

Date Relationship to the Patient