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**Heart Group of Syracuse  
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Office 315-277-2707 and Fax 315-750-3044**

**OFFICE FINANCIAL POLICY AND CONSENT FOR DISCLOSURE**

Thank you for selecting Cardiac Electrophysiology Consultants, LLC for your medical care. We look forward to assisting you with your healthcare needs. In order to prevent any misunderstanding concerning your medical care, including the responsibility for payment, please read and sign this agreement prior to treatment.

**FINANCIAL POLICY**

**Insurance.** You must provide proof of insurance at the time of your initial visit, or any time you have a change in coverage. If you do not provide us with your current insurance card, you will be considered a cash patient and you will be responsible for full payment at time of service. If you provide proof later, and within the timeline of your insurance company, we will bill your insurance and reimburse you any applicable amount as determined by your insurance. We participate in many insurance plans, including Medicare.

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and to confirm the physician whom you are seeing is contracted.

**Co-payments and deductibles.** We cannot waive copays and deductibles. You are responsible for any coinsurance, copays, deductibles, and non-covered services as required by your insurance carrier.

**No Insurance.** Payment will be due and payable at the time of service.

**Referred services.** If you are referred to another medical provider for specialized care, please be advised that such medical provider may have financial policies that differ from ours. Billing for medical services rendered by referred physicians, or labs, will be billed and handled by that provider. They may not be contracted with your insurance. The labs and Pathologists to whom we refer provide us trusted and expedient results.

**Past-due accounts.** Overdue accounts may be referred to a collection agency. Legal fees we may incur to secure past due balances will be added to your account.

**Returned checks.** For checks returned to us as unpaid by your bank, we will charge at \$50.00 fee.

**Summary.** If problems arise regarding insurance coverage issues, we will work with you to help resolve them. However, please be advised that you are, nevertheless, ultimately responsible financially for payment of medical services rendered in this office. Please feel free to discuss any financial concerns and cost of medical services before services are provided.

**ACKNOWLEDGMENT – NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge receipt of Cardiac Electrophysiology Consultants, LLC's privacy practices. This notice provides detailed information about how the practice may use and disclose my confidential health information. I understand that Cardiac Electrophysiology Consultants, LLC has reserved the right to change its privacy practices that are described in the notice. I understand that a copy of any Revised Notice will be provided and made available to me upon request.

**ASSIGNMENT: I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE FINANCIAL POLICIES OF THIS MEDICAL OFFICE. I ALSO AUTHORIZE MY INSURANCE BENEFITS TO BE PAID TO THIS OFFICE AND ITS AGENTS. I FURTHER AUTHORIZE THE RELEASE OF INFORMATION REQUIRED TO PROCESS AN INSURANCE CLAIM AND TO CARRY OUT TREATMENT.**

**Print Patient Name:** \_\_\_\_\_

**Name of person, if any, trusted to have access to your records:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

