

Cardiovascular Associates of the Peninsula

Financial Policy

We are committed to providing you with the best possible medical care and are pleased to discuss our professional fees with you at any time. Our billing department can be reached directly by calling (650) 259-5350. Your clear understanding of our financial policy is important to our relationship.

All patients must complete our patient information sheet and supply us with a copy of their insurance card(s) on a yearly basis. If any information has changed during the year, we will ask that you fill out new forms and allow us to take copies of your new insurance card(s).

Payment at the time of service is required as follows:

- HMO Patients:** Co-Payment, if applicable, provided you are eligible and you or your PCP/Medical Group has furnished us with proper pre-authorization for treatment.
- PPO Patients:** Co-Payment, if applicable, and/or annual deductible amount.
- POS Patients:** Co-Payment, if applicable. Please note, if we are not contracted with your 1st tier medical group, e.g., Brown & Toland or Hill Physicians Medical Group, the claim will be submitted using your 2nd tier "PPO" level of benefits or your 3rd tier "out-of-network" benefits. A co-insurance or deductible may apply.
- Cash Patients:** Payment in full is due at the time of visit unless a prearranged financial agreement has been arranged.

We accept VISA and MasterCard.

Billing Your Insurance:

As a courtesy to you, we will bill your insurance for your services. However, to do so, we must have the most up to date insurance information provided to us prior to services being rendered otherwise, payment in full will be required.

We will not become involved in disputes between you and your insurance company regarding eligibility, deductibles, co-payments, covered charges, etc. other than to supply pertinent medical information as required.

You are responsible for timely payment of your account.

Thank you for reviewing our policy. Please bring any questions or concerns to the attention of our billing office.

Please sign below as an indication that you have read and agree to the above Financial Policy.

Patient/Responsible Party

Date