CAMP LOWELL CARDIOLOGY

MARK C. GOLDBERG, MD, FACC

Financial Policy

Thank you for choosing Camp Lowell Cardiology as your health care provider. We are committed to the success of your treatment.

PAYMENT RESPONSIBILITY: As a patient of Camp Lowell Cardiology**,** you are responsible forall charges associated with your treatment. We accept Check, and Visa, MC and Discover,as a form of payment.

CO-PAYMENTS: All co-payments are due upon check in. Unless the patient is having a test done.

FEE COLLECTION: Payment is due upon receipt of statement. Delinquent accounts will be referred to a collection agency and may harm your credit score.

PAYMENT PLAN: Camp Lowell Cardiology offers payment plans at the discretion of the practice for balances of $200.00 or more.

RETURNED CHECK FEE: Camp Lowell Cardiology will access $45.00 fee on all returned checks

INSURANCE CLAIMS: Camp Lowell Cardiology contracts with many insurance carriers,as a curtesy to our patients we will bill your insurance company. Please contact your insurance carrier prior to your appointment if you have any concerns about your coverage and/ or benefits.

REFERRAL POLICY: If your insurance carrier requires a referral, it is your responsibility to ensure the office has received one prior to your appointment.

MISSED APPOINTMENTS: Camp Lowell Cardiology requires at least 24-hour notice for all cancellations. There be a $25.00 fee for a missed office visit and $50.00 for Echo missed accessed at the discretion of the office.

Tele-Med: Camp Lowell Cardiology will charge $25.00 for a 10 minute phone call.

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance please read and sign below: I hereby assign all medical and/or surgical benefits to Camp Lowell Cardiology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether paid by my insurance carrier. I understand that I am ultimately responsible for my health care and follow up appointments are important to my health care. I understand that I must assume the health consequences of missed follow up care. I hereby authorize Camp Lowell Cardiology to release all information necessary to secure payment. I have read, understand and agree to the above financial and health care policy for payment of professional fees. I understand that I, as the patient, am ultimately responsible for payment of all professional fees.

SignaturePrint NameDate

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