CARDIOFIT MEDICAL GROUP, INC.

Fin Policy

CARDIOFIT

Financial Policy

A copy of this form will be considered acceptable as the original

1. **SELF-PAY**: If you do not have insurance coverage, payment is due at the time of service.
2. **COPAYMENTS**: Your copayment is always due at the time of service. Our contractual agreement with your carrier prevents us from waiving your required copayment amount. _____ Initial
3. **BALANCE DUE DATE**: The "patient balance" is due within 15 days of the statement date unless you have made other arrangements with the business office. A finance charge is added to any outstanding balance at 12% annually (1% monthly). We will collect all outstanding patient balances prior to each visit. _____ Initial
4. **MISSED APPOINTMENTS**: If you cannot make your scheduled appointment time, please notify the office at least 24 hours prior to your scheduled appointment time to reschedule or cancel. A $50.00 charge will be assessed for missed appointments if we do not receive notification within 24 hours. _____ Initial
5. **RETURNED CHECKS**: A $40.00 service charge will be assessed for returned checks. _____ Initial
6. **LABORATORY SERVICES**: If you have blood drawn, you may be billed separately by the laboratory that conducts the test(s). If your insurance company requires a specific laboratory for the processing of your blood work, it is your responsibility to notify the clinical staff at the time of the blood draw. _____ Initial
7. **REQUEST FOR CERTAIN FORMS**: Forms that are requested by a patient take a considerable amount of staff time to process, and often take away from the time spent with a patient. To offset this cost, I understand that I will incur a charge of $25.00 for EDD, Work Disability, or other Government related forms. Forms that require a company letterhead, such as a 'return to work authorization' will incur a charge of $15.00. _____ Initial
8. **BILLING ERRORS**: Call to correct any billing errors promptly. If you ignore our billing statements or telephone calls, we can only assume that you do not intend to pay for the medical services that were provided in good faith, and your account will be forwarded to an outside collection agency. _____ Initial
9. **REFERRALS**: Some insurance plans require that a referral from the primary care physician be obtained prior to being seen. It is the responsibility of the patient to obtain this referral. If a referral has not been obtained, you may be responsible for a larger portion of your bill. _____ Initial
10. **PERSONAL INJURY**: We will not be a party to any litigation suits filed for personal injuries. We require payment in full and any payment from litigation is to be sought by you for reimbursement. _____ Initial
11. **WORK-RELATED INJURIES**: Pre-authorization for care is the responsibility of the patient. We will attempt to obtain pre-authorization from your insurance company for any medically indicated services. If we are unable to obtain the pre-authorization, you will be responsible for payment in full at the time of service. If your worker's compensation carrier has not paid your account within 45 days of the date and service, the owed balance will become the responsibility of the patient. _____ Initial

CardioFit Medical Group, Inc. files insurance claims for patients as a courtesy. **Regardless if you have an insurance plan, you still have full responsibility for payment of Deductibles, Co-Pays, and Non-Covered Services.** It is also the patient's responsibility to know if the physician he/she is seeing is a participating provider with his/her health plan. By initialing the document, you acknowledge that you have read each policy and accept the terms as outlined.

My Signature below acknowledges that I have read and accept the above statements and attached documents.

Signature: Date: