FINANCIAL POLICY AND TREATMENT CONSENT

Our Financial Policy: Our physicians and staff are very concerned about the cost of your health care and want to address some issues related to the cost of medical services in our office. Considerable care has been taken in setting our fees. We want to assure you that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

HMO and PPO Members: If you are a member of an HMO or PPO in which we participate, your co-payment is required at the time of service. You are responsible to see that we have a current referral/authorization on file if your insurance carrier requires one. If we do not have this referral/authorization at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to your Primary Care Physician prior to being treated to obtain this. If you are not sure that our physicians are providers for your insurance, please contact your insurance carrier directly for clarification. Our agreement is with you, not your insurance company. Although we will assist you in submitting your claim to your insurance carrier, you are ultimately responsible for the services you receive. Payment to our office is neither contingent nor dependent upon your insurance carrier.

We are pleased to accept cash, checks, VISA, MasterCard, Discover and American Express.

Medicaid: We are Medicaid providers. Please bring your current card to each visit.

Divorced Parents: Please remember that the adult bringing the child for treatment is responsible for payment of the bill. If the court has awarded custody of minor children to one person and financial responsibility to another, the person bringing the child is still responsible for payment. The patient can bill their estranged, but it is not the responsibility of the practice. If there is a court order on file for a parent to carry medical insurance coverage on the minor child, a copy of the court decree will need to be made available for our file to ensure proper medical claim filing and payment of claims by the carrier(s).

Foster Parents: Please bring appropriate guardianship papers for our files to ensure proper treatment authorization and HIPAA standards can be complied with.

Treatment Consent: I am the parent/legal guardian of the below named patient and hereby authorize treatment by the physicians of Children's Cardiology Associates/Pediatrix. I understand the financial policy of the practice and the release of medical information needed for this or a related claim and hereby assign and transfer payments directly to Children's Cardiology Associates/Pediatrix for benefits that would otherwise be payable to me.

Patient Name:_____ DOB:_____

Parent/Legal Guardian Signature:_____ Date: _____