

 HFCCA **Hampden & Franklin County Cardiovascular Associates**

 **Hampshire County Cardiovascular Associates**

**PATIENT FINANCIAL AGREEMENT**

**Patient Responsibilities**

* You are responsible to provide us with accurate billing information at the time of service.
* If your insurance company requires you to choose a primary care provider (PCP) – it is your responsibility prior to your visit to ensure that you have authorization for your visit with us.
* Our billing staff is available to provide you with assistance but cannot resolve disputes between you and your insurance company.

**Co-Payments**

* Your insurance company requires you to pay your copay at the time of each visit.
* Your copay may be paid with cash, check, credit card or debit card.
* If your check is returned a $25.00 returned check fee will be assessed.
* If you do not have insurance coverage, you will be expected to pay for you visit in full upon arrival for your appointment.
* If we cannot verify your insurance coverage at the time of your visit, we require a minimum of $100.00 deposit per office visit.

**Deductibles**

* It is your responsibility to understand any deductibles that may apply to you under your Insurance Policy.
* Our billing department will send you a statement of the amount your insurance company has determined is applied to your deductible and is owed by you.

**No-Show Policy**

* It is your responsibility to read and understand any fees that may apply to you under the Hampden and Franklin County Cardiovascular Associates/Hampshire Cardiovascular Associates No-Show Policy or insufficient notice of intent to cancel appointment(s).
* Medicaid/MassHealth are exempt from the No-Show Policy.
* Our billing department will send you a statement reflecting payments owed by you.

**Insurance Information**

* It is your responsibility to ensure that we have accurate insurance information. Presenting an invalid or inactive insurance card will result in full payment by you.
* Medical insurance does not always cover the entire cost of your medical care. You are responsible for payment if your insurance company refuses to pay for a service.

**Home Address and Telephone**

* You will be asked to complete a patient registration form that asks for important information about you. Please complete this form to the best of your knowledge and keep us informed of any changes on subsequent visits.
* It is important that we have accurate information on the guarantor. This is the person who is financially responsible for your bills.

**Assignment and Release**

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my Physician to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. Recent changes in insurance regulations shorten the time frame for claim submissions. I agree to pay any out-of-pocket expenses in full to Hampden and Franklin County Cardiovascular Associates/Hampshire Cardiovascular Associates within thirty days from the date of my visit for uncovered, denied services by my presented insurance coverage or for No-Show fees.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_