Horizon Cardiology

10-14 Saddle River Road
Fair Lawn, NJ 07410
(551) 246-3008

FINANCIAL AGREEMENT

In order to control our cost, payment is expected when services are rendered unless other arrangements are made in advanced. Please be advised this office does not participate with Medicaid.

I authorize Horizon Cardiology to release to my insurance carrier upon their legal request any information acquired during the course of my examination and/or treatment and permit payment directly to Horizon Cardiology. *Patients are responsible for any co-pays, deductibles and co-insurance from the insurance company. Testing may not be covered 100% which the patient is responsible for knowing his/her benefits with their insurance policy. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.* In the event that my outstanding balance requires additional collection activity, I acknowledge that I will be responsible for any such collection fees associated with this action; this includes, but is not limited to, fees charged by this office, legal/court fees and physician fees.

MEDICARE PATIENTS: I understand that Medicare may deny payment for certain services such as services they determine are not medically necessary and I agree to be personally and fully responsible for any such charges.

ALL NON-MEDICARE PATIENTS: I understand that it is my responsibility to know my insurance policy and to bring the most recent insurance card to each visit. *If my plan requires a referral and I fail to bring one, I understand that I will not be seen by the physician unless I pay cash for the visit.* If I choose to pay cash, I will be provided with the appropriate documentation from the office to submit the claim on my own behalf. In the event that there is a discrepancy in the amount reimbursed by my insurance carrier, I agree to pay the rate set by Horizon Cardiology. This agreement, therefore, supersedes any purported terms claimed by any managed care or other insurance company.

Please be advised that for testing that requires us to pre-order the medication, you will be charged for the cost of the medication.

I hereby authorize use of this signature on all submissions of insurance claims.

_____ _____

Patient/Guardian Signature Date

_____ _____

Name above if other than Patient Relationship to Patient