

## MICHIGAN HEART GROUP, P.C. FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

**CO-PAY/DEDUCTIBLE PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE.**

**NON-INSURED PATIENTS WILL NEED TO EITHER ARRANGE A PAYMENT PLAN IN ADVANCE OF APPOINTMENTS OR PAY IN FULL AT THE TIME OF SERVICE.**

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. We accept cash, personal checks, VISA, and MasterCard.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling further appointments. If payment arrangements are not being adhered to you may be terminated from the practice. We realize that financial difficulty is a reality. In such circumstances, we may advise you to seek your healthcare through a clinic or health bureau.

### INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

### MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the **Michigan Heart Group** Financial Policy. I agree to assign insurance benefits to **Michigan Heart Group** whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative:

\_\_\_\_\_

Date: \_\_\_\_\_

Pt. # \_\_\_\_\_

Physician \_\_\_\_\_