Maui Cardiology, Ltd.

FINANCIAL POLICY

We are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED.

HMO/PPO INSURANCE COVERAGE Co-payment and deductible must be paid at the time of service. If we are under contract with your insurance company, we will file your insurance.

MEDICARE Your deductible and 20% of the allowable charges are due at the time of service, however since we are Medicare providers we will file your Medicare and if we do not know the allowable charge for a specific service, we will bill you after Medicare pays. Please bring your Medicare EOB to show you have met your deductible.

RETURNED CHECK POLICY Returned checks are subject to a $20 service fee and you will lose your privilege to write checks in our office.

FINANCIAL AGREEMENT We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however that:

1. **Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.**
2. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. yearly physicals).**

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. All charges are your responsibility from the date services are rendered.

I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy.

If you have questions about the above information of any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy.

Patient's Signature: X_____ Date: ____/____/_____

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