Cardiology of San Antonio, P.A.
2833 Babcock, Suite 210 San Antonio, Texas 78229 Tel: (210) 949-1300 Fax: (210) 949-1475

FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED 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 check, debit and credit cards. There is a $25.00 service charge for returned checks.

Patients with an outstanding balance of 60 days overdue must make arrangements with our billing department for payment prior to scheduling appointments.

REFUNDS

Overpayments will be refunded within 15 days.

MISSED APPOINTMENTS/NO SHOWS/LATE CANCELLATIONS:

Missed 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 should be made 24 hours prior to the appointment. We reserve the right to charge for frequent rescheduling (>3 in one year) missed or late-canceled appointments. Excessive missed, rescheduling and/or cancellation of appointments may result in you being discharged as a patient from the practice.

I have read and understand the Cardiology of San Antonio, P.A. Financial Policy. I agree to assign insurance benefits to the Cardiology of San Antonio, P.A. 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 fees charged by the collection agency for costs of collections.

Signature of patient or authorized representative:

_____ Date: ____/____/_____

CARDIOLOGY OF San Antonio, P.A.

CONSENT FOR RELEASE OF HEALTH INFORMATION

Date_____

I hereby authorize _____to release the following information from the health records of:

Patient Name:

_____

Address:

_____

City, State, Zip_____Tel. # _____

Date of Birth: _____SS#_____

Information to be released to:

Cardiology of San Antonio, P.A.
2833 BABCOCK, Suite 210
San Antonio, Texas 78229
Tel. (210) 949-1300
Fax # (210) 949-1475.

Information to be released:

___History and Physical
___Consultation Report
___EKG, Echo, Stress Report
___Any dictation or hand written progress notes

___Others_____
_____
_____

Signature: _____ _____Date_____ (patient or representative).

Relationship to Patient_____

Witness: _____