CARDIAC RHYTHM DIAGNOSTICS, P.C.

115 E 57TH STREET, SUITE 1450
NEW YORK, NY 10022
PHONE: 212-688-8799

FINANCIAL POLICY

Thank you, for choosing us as your Cardiac health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy that we ask you to read and sign prior to any treatment.

ALL FORMS MUST BE COMPLETED AND SIGNED BEFORE SEEING A DOCTOR

- **MEDICAID:** I understand that Cardiac Rhythm Diagnostics, P.C. doesn't participate in **MEDICAID**
- **PRIVATE INSURANCE:** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, YOU ARE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF VISIT
- **PARTICIPATING INSURANCE:** All co-payments and deductibles are payable at the time of visit. Your signature below authorizes payments to us for our services. You are responsible for obtaining a referral number. If you do not, you are required to pay at the time of visit as an "out of network". If your insurance does not cover a special procedure and you would like it performed anyway, you are required to sign an acknowledgement and pay at the time of service. This waives your right to submit it to your carrier for denial.
- **MEDICARE INSURANCE:** We accept assignment. We will electronically submit your claim. Medicare will mail an Explanation of Benefits to you. You can then submit this to your co-insurance. I request that payment of authorized Medicare benefits be made to me or on my behalf to CARDIAC RHYTHM DIAGNOSTICS, P.C., for services furnished to me. I authorized any holder of medical information about me to be released to the healthcare financing administration agents any benefits related services

*******MEDICARE BENEFICIARY NOTICE*******

Medicare will only pay for services that it determines to be "reasonable and necessary" under 1872(a)(1) of Medicare law. I have been notified on the date indicated that ***Medicare is likely to deny payment for test/treatment if I exceed the prescribed frequency for either the prescribed test/ treatment.*** I agree to be professionally responsible for payment if Medicare denies payment.

*******RELEASE OF INFORMATION*******

I hereby authorize Cardiac Rhythm Diagnostics, P.C. to release to insurance carriers or others who are, or may be financially responsible for my medical care, all information needed to substantiate payment for my medical care. I have read the above and agree to this policy as stated.

PRINT NAME_____**DATE**_____

SIGNATURE_____