Kansas Heart Office Plaza
9350 E. 35th St. N. ◦ Suite 101
Wichita, KS 67226

CARDIOVASCULAR CONSULTANTS OF KANSAS, P.A.

Office: 316-265-1308
In Kansas: 1-800-362-1093
Fax: 316-265-4480

Financial Policy

The following statement is our Financial Policy. Please read and sign as your acknowledgement and understanding of the following. Quality care is our priority at Cardiovascular Consultants of Kansas. Accordingly, our charges are considered to be usual and customary for our area and specialty.

Copays/Coinsurance/Deductibles

As you check in for your visit, we will collect your copay, coinsurance, and/or deductible.

Insurance

As a courtesy to our patients, we will file your claims with the insurance carriers you have provided. Once these attempts have been resolved, any remaining balance will become the patient's responsibility. Although we may be able to estimate the payment from your insurance company, it will ultimately be your insurance company that determines the final payment based on your eligibility and benefits. Please bring your insurance cards with you to your visits so we can ensure that the information we have on file is correct and up to date. In the event of any changes in coverage, please contact our office with the new information. Out of date information may result in patient responsibility for the visit.

Authorization to Pay Benefits to Physician

I hereby assign payment directly to Cardiovascular Consultants of Kansas for the medical benefits, if any, otherwise payable to me for services described, but not to exceed my indebtedness to Cardiovascular of Consultants of Kansas for those services.

Referrals

You are responsible for obtaining a referral from your primary care provider, should it be required by your insurance, for any services you may receive at Cardiovascular Consultants of Kansas with any of our providers. Failure to obtain a necessary referral may result in lower payment from the insurance company and more patient responsibility.

Self-Pay

Should you not have insurance coverage, you will be responsible for making a $50 payment at the time of your office visit. If your provider determines that more testing is required, you will be responsible for paying for 50% of the estimated cost prior to the testing. Please contact our insurance staff prior to the testing to determine this estimate. Your health is our top priority. Please contact our office regardless of your current coverage status and reasonable accommodations can be made.

Cancellations or Missed Appointments

We require a 24-hour notice for appointment cancellations. Appointments scheduled for a clinic visit may be charged a $25.00 fee if missed and not cancelled at least 24 hours prior to the appointment. Appointments scheduled with our nuclear lab require materials to be ordered the day before the scheduled test. Missed appointments, without a 24-hour notice of cancellation, will be charged a fee of $250.00 for these materials if they are wasted.

Event Monitors

Certain testing may require you to take equipment home with you for a number of days. You are responsible for returning this equipment to the office when the testing is complete. Should the equipment not be returned, or it is returned in a damaged or nonfunctioning state, you will be responsible for the full cost of a replacement.

Returned Checks

If a check is returned from the bank due to insufficient funds, a $35.00 charge will be applied to your account to cover the processing fee with our bank. You may be placed on a cash only basis following any returned check.

By signing below, you understand this financial policy including your responsibility for timely payment of the account. You will receive a statement for services which are due and payable upon receipt. We accept cash, checks, and Visa, Mastercard, and Discover credit cards. If timely payment is not received, the account may be sent to an outside collection agency.

I have read the Financial Policy. I understand and agree to this Policy.

X_____ Date_____
Signature of Patient or Responsible Party

X_____ Patient DOB _____
Patient Name Printed