Gopala Krishna Rao, M.D., M.R.C.P., R.P.V.I., F.A.C.C.

Board Certified in Cardiology, Echocardiography & Vascular Interpretation

FINANCIAL RESPONSIBILITY AGREEMENT

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Your insurance policy is a contract between you and your insurance company. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Preauthorizations

If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Returned Checks

The charge for a returned check is $38.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes medical services and/or visit, preventive exam or physical, lab testing, x-ray, EKG and any other screening services or diagnostic testing ordered by the physician or the physician staff. I understand and agree it is my responsibility to know if my insurance policy has any deductible, co-payment, co-insurance, out-of-network or any type of benefit limitation for the services I receive. I understand and agree it is my responsibility to

know if the physician or provider I am seeing is an in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or a higher out-of-pocket expense to me. I understand and agree to be financially responsible for all services rendered.

Patient Signature: _____ Date: _____