

East Tennessee Pediatric Cardiology, PC
2001 Highland Ave, Suite B
Knoxville, TN 37916
Ph: 865-971-6897
Fax: 865-971-6817

Financial Policy

Welcome to our practice! We strive to provide the best possible medical care for you/your child. Our financial policy explains what we need from you, as well as the procedures our office follows to correctly process insurance claims. This policy is important to help us efficiently handle financial matters, so we can provide you/your child with the highest quality medical care. Please return this form to the front desk once the policy has been completed and signed. A copy is furnished to you upon request.

Required from Patient Prior to Treatment:

Updated demographic information and current insurance card(s)
Referral from primary care physician/referring physician if required by the insurance company
Co-payment determined by the insurance plan (if applicable)

Insurance Filing:

We will submit a claim to the insurance company that you have provided. We will accept the payment allowed from the insurance company in which we participate. The patient/parent/legal guardian will be responsible for any deductible or co-insurance information determined by the insurance company. Any non-covered services are the full responsibility of the patient/parent/legal guardian. Health insurance coverage is an agreement between the patient/parent/legal guardian and the insurance company, and the doctor's bill for service is an agreement between the patient/parent/legal guardian and the doctor.

Patient Billing:

We will bill the patient/parent/legal guardian subsequent to any insurance payments. The patient/parent/legal guardian is fully responsible for any remaining balances or non-covered services that the insurance company determines. Payment is due upon receipt of the statement from our office unless other arrangements have been made with the billing office. Overdue accounts will be sent to an outside collection agency, and the patient/parent/legal guardian may be discharged from the practice.

Self-Pay Patients:

Payment is due at the time of service for self pay patients. Payment arrangements with the billing office can be made prior to treatment. Our office accepts cash, check, Visa, MasterCard, and Discover.

Service Charges:

There is a \$20 service charge on all returned checks. This charge will be added to the outstanding balance. There is a \$20 service charge for co-payments that are not made within 24hrs of treatment in the office.

- I UNDERSTAND THAT EAST TENNESSEE PEDIATRIC CARDIOLOGY, PC EXPECTS PAYMENT AT THE TIME THAT SERVICES ARE RENDERED _____(initial)

- I UNDERSTAND THAT THE OFFICE WILL FILE WITH MY INSURANCE COMPANY, BUT THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES _____(initial)

- I UNDERSTAND THAT OVERDUE ACCOUNTS WILL BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY _____(initial)

I acknowledge that I have read and understand the above financial policy for East Tennessee Pediatric Cardiology, PC.

Parent/Legal Guardian/Durable medical power of attorney:

Signature: _____ **Date:** _____