Preventive Cardiology and Internal Medicine Associates P.L.

PAYMENT & INSURANCE POLICY/ PCAIMA EXPECTATIONS

Copay's, deductible, outstanding balances & fees (Ex. no show fee, printing, lab & credit/ debit card convenience fee etc.) are expected at the time of your service if applicable. We offer the following payment options:
CASH or CHECKS or CREDIT/ DEBIT CARD*

(* No dispute refund, or return is accepted if payment was made using credit or debit card. If needed, a refund check or credit will be issued to patient.)

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INSURANCE

Patient Name: ________________________________ **Insurance Name:** _________________________

Patient Co-pay__________________________________ **Deductible**_____________________________

Patient is responsible for all payments including copay, deductible, any non-cover charges, and fees (for example: printing, no show, lab & credit/debit card convenience fees etc.). An insurance plans intend to cover most, but not all the cost of your care. Most plans include coinsurance provisions, a deductible, and certain other expenses which must be paid by the patient. Even though you have insurance, you will be expected to make an estimated payment for that portion not covered by your insurance plan on the day of service.

As a courtesy, we will file insurance claims on your behalf, however, Medical Insurance does not pay for everything (and PCAIMA does not contract with insurers for all services that we provide), even some care that you or your health care provider have a good reason to think you need. We will work with you and your insurance provider to ensure you receive the maximum benefits to which you are entitled.

Our office has several providers and we alternate your appointments between your provider and ARNP for your visit. We hope you comply with the services and recommendations we provide, as our goal is to build positive therapeutic relationships that work for the benefit of the patient.

I have read, understand, and will follow the Payment & Insurance policy/PCAIMA Expectations. Also, I understand that this policy will stay in force as long as I am an active patient with PCAIMA.

Signature (parents please write your name and sign below if patient is under 18):

______________________________________ **Date** ________________________________