Aneley Yegezu Hundae, M.D., FACC

Board Certified in Cardiology, Nuclear Cardiology,
Advanced Heart Failure, Echocardiography, Internal Medicine

In an effort to control costs and provide the best possible care for our patients, we have established the following financial policy. We hope that this will answer any questions you may have in regard to your financial responsibilities.

1. All Insurance co-pays and deductibles are due at the "time of service". For your convenience, we accept Visa, MasterCard, Discover, debit card, personal checks, and cash as forms of payment at our facility. If your check is returned to us for any reason, you will be charged a $25.00 fee.
2. Uninsured/ self-pay patients are required to pay a "good-faith" deposit of $250.00 upon your first office appointment. If our services are more than $250.00 you will be required to make a financial payment plan for any future charges
3. Keep in mind that your insurance coverage is an agreement between ou and your insurance company. As a courtesy to our patients, we will file your initial claim for you. For Medicare patients, we will file your secondary and additional insurances as well, if payment is not received within 30 days, or a balance remains after payments are received form your insurance company, you may be billed for the balance. Insurance made directly to the patient for PC Cardiology services rendered are due to PC cardiology immediately.
4. Not all Insurance plans cover all services. If your insurance company determines a service is "not covered", you will be responsible for the balance. Additionally, if your insurance only covers A percentage of the service, you are responsible for the remailing portion.
5. IN the event that you have a "patient due" balance on your account at the time of visit, you will be asked to bring your account current prior to your appointment with the doctor. If you are unable to do this, we will be happy to work out a "payment plan" with you.
6. For all outstanding balances, a payment plan structure may be set up as follows:

Balance Due	**# of Months**
Less than $100.00	2 Months
$100.01 - $300	3 Months
$300.01 - $500	5 Months
$500.01 - $800	6 Months
$800.01 -$ 1500	8 Months
$1500.01 - $2500	10 Months
$2500.01 - $4000 +	12 Months

7. Any accounts with an outstanding balance after 90 days of notice, without pending insurance and /or financial arrangements, will be sent to an outside collection agency. If this is the case, you may be required to pay for any further appointments or tests, in full at the time of service.

8. A patient under the age of 18 must be accompanied by a parent or legal guardian to authorize treatment and make financial arrangements. If a custodial parent is present but does not carry the patient on their personal insurance, we can submit charges to the patient's insurance provider. However the , the parent presenting the child will be billed for any balance not covered by the patients insurance. Patients 18 and older are financially responsible for charges incurred during each visit.
9. We require notification at least 24 hours in advance if you are unable to keep your appointment (s) to avoid a $25.00 no-show fee. No-show fee for Echo or nuclear testing is $150.00 No-show fees are billed to your account since insurance companies will **NOT** pay.
10. We will make every effort to work with you; however, reasons such as, but not limited to, failure to keep appointments, non-compliance with prescribed treatment plan, abusive behavior towards staff members, and /or failure to pay your bill may result in dismissal from the practice. If dismissed from our practice you are eligible for emergency treatment ONLY. Emergency care is provided for a maximum of 30days. After that time, you will be required to seek medical treatment from another physician/practice.

I have read and understand Port Charlotte Cardiology's policy and agree to be bound by its terms. I also understand that such terms may be amended without notice by Port Charlotte Cardiology at any time..

Signature of Patient (or responsible party, if under 18) Date

Print Name of Patient Date of birth Patient account #

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