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Office and Financial Policy (side 1)

Thank you for choosing Pikes Peak Cardiology, LLP. for your medical needs. To keep you informed of the office and financial policies we ask that you read and sign the information below.

UNINSURED PATIENTS Payment for services is due in full at the time of service. For your convenience, we accept VISA, MasterCard, Discover, American Express, cash, checks and money orders.

INSURANCE PATIENTS We will bill most primary and secondary insurance carriers for you upon receipt of a valid insurance card. Please be aware that although we participate with most insurance companies, it is your responsibility to make sure we are a participating provider with your plan. We do not participate with any out-of-state Medicaid plans, Colorado Access Advantage or CHP+ administered by Anthem BCBS.

CO-PAYMENTS All specialty office co-payments are due at the time of service, whether you are seeing a Physician, a Physicians Assistant or a Nurse Practitioner.

DEDUCTIBLES, CO-INSURANCE AND NON-COVERED SERVICES Our office requires payment in full or a deposit to be made at the time of appointment on certain procedures or diagnostic testing.

Since your insurance policy is an agreement between you and the insurance carrier, we will not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If an insurance carrier has not paid your services within 45 days of billing, we will transfer the balance to you for payment in full.

REFERRALS Our office will attempt to get prior authorization from your Primary Care Physician or your Insurance Company for you. However it is ultimately your responsibility to make sure that there is a referral in place. In the event this information is not received we may cancel your appointment or request that you sign a waiver accepting responsibility for payment.

AUTO OR WORKER'S COMPENSATION We do not routinely provide services for auto or worker's compensation patients. We will however, provide a consultation at the request of your case manager for surgery clearance. We will require the case manager's name, billing address, claim number and pre-authorization. If this information is not provided at the time of service your appointment may be cancelled or you will be responsible for payment in full.

Please see other side

Office and Financial Policy (side 2)

CANCELLATION POLICY Our office requires 24 hours notice for the cancellation of appointments.

ADDITIONAL CHARGES THAT YOU MAY BE RESPONSIBLE FOR

Missed Appointments \$30.00

Finance Charge for Co-pays \$25.00

Returned Checks \$20.00

Copies of Medical Records \$14.00 first 10 pages, .50 page 11-40, .30 each additional page

OVERPAYMENTS We will not refund credit balances less than \$10.00.

PAYMENT ARRANGEMENTS We will allow you to carry a balance on your account upon approval for one of our payment arrangement plans. You may be required to provide us with a credit card for automatic monthly withdrawals.

COLLECTION AGENCY We refer all unpaid accounts over 60 days past due to a third party collection agency unless the account has been approved for payment arrangements.

I acknowledge full financial responsibility for services provided to me by Pikes Peak Cardiology. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including co-payments, coinsurance and deductibles. I understand co-payments are due at the time of service as well as any prior balance I may owe. I understand that under provisions of HIPAA (The Health Insurance Portability and Accountability Act of 1996), my insurance company and/or employer group plan administrator may be notified if I fail to fulfill my financial obligations for the payment of deductibles and co-insurance. I agree to all reasonable attorney fees and collection costs in the event I default on payment of my charges. I also consent that direct payment of authorized insurance benefits are paid on my behalf to Pikes Peak Cardiology.

PATIENT'S NAME (Please Print _____)

PATIENT'S SIGNATURE _____ **Date** _____