INSURANCE PAYMENT PLAN

We will file insurance with your provider according to your individual plan. The patient will be responsible for any deductible, co-pay or co-insurance. Referral numbers required by some managed care plans must be given prior to the time of service; otherwise the service becomes the patient's responsibility. For all private insurance companies, the patient will be responsible for payment at the time of service. We will provide the necessary information for the patient to file for reimbursement. I have received a copy of the WellStar Cardiovascular Medicine Financial Policy.

Our fees for procedures will vary depending on the complexity of your problem and the services provided. If a procedure is performed outside of our facility, we will gladly assist you in pre-certification, second opinions, etc.

I understand that it is my responsibility to obtain an authorization or referral from my primary care physician as specified by my insurance plan. If I do not have this authorization at the time of my visit, I understand that it will be necessary to reschedule my appointment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to WellStar Cardiovascular Medicine for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

INFORMATION RELEASE

I hereby authorize treatment of myself by WellStar Cardiovascular Medicine, and authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, confidential information necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities.

A photocopy of these assignments shall be valid as the original.

Patient (please print)_____ **Date**_____

Signature _____

Parent / Guardian (please print) _____