LAS SENDAS CARDIOLOGY

3514 N. Power Rd. Suite #107 Mesa, AZ 85215 P: 480-361-9949 F: 480-361-9969

FINANCIAL POLICY

NAME: _____BIRTHDATE: _____ SSN: _____

WELCOME TO LAS SENDAS CARDIOLOGY. WE ARE COMMITTED TO GIVING YOU THE BEST CARE POSSIBLE. WE WOULD LIKE TO TAKE THIS OPPORTUNITY TO INFORM YOU OF OUR OFFICE FINANCIAL POLICY.

WE WILL BILL INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS PROVIDED WE HAVE YOUR CURRENT INSURANCE INFORMATION AND ANY NECESSARY REFERRALS. SHOULD YOUR INSURANCE REQUIRE A REFERRAL, AND WE HAVE NOT RECEIVED IT PRIOR TO YOUR APPOINTMENT, YOU WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. WE ACCEPT PAYMENT FROM INSURANCE COMPANIES, BUT REQUIRE THAT YOU PAY YOUR PORTION, INCLUDING CO-PAYS, DEDUCTIBLES, OR COINSURANCE AT THE TIME OF SERVICE. RETURN CHECK FEE WILL BE ACCESSED AN ADDITIONAL $35.00.

THIS OFFICE BILLS ONLY FOR SERVICES PERFORMED BY DR. AFROZE AHMAD.

AS A COURTESY, WE WILL ATTEMPT TO CONTACT EVERY PATIENT TO REMIND THEM OF THEIR APPOINTMENT. HOWEVER, IT IS THE RESPONSIBILITY OF THE PATIENT TO ARRIVE TO THEIR APPOINTMENT ON TIME. WE ASK THAT YOU NOTIFY US 48 BUSINESS HOURS IN ADVANCE TO CANCEL AND/OR RESCHEDULE YOUR APPOINTMENT. **PLEASE BE AWARE THAT FAILURE TO DO SO MAY RESULT IN A MISSED APPOINTMENT FEE OF $50.00.**

IT IS YOUR RESPONSIBILITY TO INFORM THIS OFFICE OF ANY/ALL CHANGES IN YOUR NAME, ADDRESS, PHONE NUMBER AND INSURANCE COVERAGE.

SHOULD YOUR INSURANCE COMPANY DENY PAYMENT FOR YOUR MEDICAL CHARGES AND/OR TREATMENTS YOU AGREE TO PAY THE OFFICE CHARGES FOR THE SERVICES RENDERED BY DR. AFROZE AHMAD. DELINQUENT ACCOUNTS WILL BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY IF UNPAID AFTER 60 DAYS WITHOUT FURTHER NOTICE. IN THE EVENT THAT YOUR ACCOUNT IS TURNED OVER FOR COLLECTIONS, YOU ARE RESPONSIBLE FOR ALL ASSOCIATED COLLECTION, COURT, AND ATTORNEY COSTS.

I HAVE READ THE ABOVE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THESE TERMS.

PRINTED PATIENT NAME: _____ DATE _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:_____