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Cardiovascular Research Associates, PA
300 Beardsley Lane C-101
Austin, TX 78746
Phone (512)454-3333 Fax (888) 894-0872

Financial Agreement

Thank you for choosing this practice. We are committed to the success of your medical treatment and healthcare. Please understand that payment of your bill is part of this treatment and care. By signing below, you are confirming your understanding and acceptance of our financial policy.

1. If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. **However, you will be responsible at the time of service for payment of the following, if applicable:**

   a. Your annual deductible
   b. Co-payments and co-insurance
   c. Charges for any non-covered expense

We make every effort to help determine your benefits in advance and will attempt to apprise you of your out-of-pocket expense, before any in-office testing is performed. However, you are responsible for knowing and understanding your insurance benefits.

2. We are a Non-Participating Medicare provider therefore, we charge the We will bill Medicare directly on your behalf. You are responsible at the time of service for:
   a. The annual Medicare deductible
   b. The 20% not covered by Medicare, unless you have secondary insurance
   c. Any charges for non-covered services.
3. If you have no health insurance, full payment for services rendered is expected at time of service.
4. In the event that we receive a returned check due to insufficient funds, a fee of $35.00 will be charged to your account, and payment is due upon receipt of your statement.
5. When we schedule an appointment for you, we are reserving time solely for your healthcare needs, and we will not schedule another patient during your slot. As a result, we require twenty-four hour notice for cancellation; if you fail to appear for your appointment without calling 24 hours in advance, a **$50.00 charge** will be assessed to your account.

For your convenience, we accept cash, check, MasterCard, Visa, Discover, and American Express. If you have any questions, please do not hesitate to ask us. We are here to assist you in any way possible.

Your signature below signifies that you understand and agree to our financial policy and your responsibility regarding charges incurred in this office.

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Patient/Guardian Signature Date