

CARDIOVASCULAR & THORACIC SURGERY, PLLC

Assignment of Benefits

I assign payment to Cardiovascular & Thoracic Surgery, in accepting this assignment of benefits for all therapy and applicable and otherwise payable to me but not to exceed the reasonable and customary charge for these services rendered by said group.

Agreement of Payment

I, the undersigned, do hereby understand and agree that I am responsible for all charges to my account.

I further understand that all insurance claims are filed as a courtesy by Cardiovascular & Thoracic Surgery PLLC, as per the contractual agreement with my insurance carrier and that I am responsible for any unpaid portion of the account balance.

I understand that Cardiovascular & Thoracic Surgery, PLLC, will allow sixty (60) days for payment to be made by the insurance carrier at which time I may be held responsible for any unpaid portion of the balance.

I understand that there will be a twenty five dollar (\$25.00), No Call/No Show fee if the appointment is not cancelled within 24 hours, before the appointment time and/or if I do not show for my scheduled appointment. I understand this fee will be charged to my account and due at the time of my next appointment. This will be my financial responsibility and not that of my insurance carrier.

If I am not covered by an insurance carrier, I agree that I am responsible for all charges at the time of services are rendered unless financial agreements have been made in advance, with the office manager.

Should my account become past due and is transferred to an attorney and/or collection agency, I understand that I will be responsible for all attorney, court and any other associated fees with the collection of this account.

Patient/Responsible Party Signature

Date

Cardiovascular & Thoracic Surgery Employee

Date