



# NM Cardiac Care, P.C.

Providing Comprehensive Cardiovascular Care,  
Interventional Cardiology  
and Peripheral Vascular Intervention



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Board Certified in Cardiovascular Disease  
and Interventional Cardiology,  
Peripheral Vascular Intervention

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Board Certified in Cardiovascular Disease,  
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Echocardiography

<b>Payment Responsibility</b>	The patient or his legal representative is ultimately responsible for all charges incurred.
<b>Non-Discrimination of Services</b>	Necessary medical services will be provided regardless of the Patient's ability to pay.
<b>Assignment of Benefits</b>	The physician will bill insurance plans as a courtesy to its patients if the patient provides the required insurance information and signs an assignment of benefits statement.
<b>Partial Insurance Coverage</b>	Patients with insurance policies that cover only a portion of treatment must pay the difference between actual charges and the anticipated insurance payment. This payment may be requested and is due at the time of service. A pretreatment may be required.
<b>Co-payments</b>	The patient or his legal representative is responsible for insurance Co-payments at the time of service.
<b>Uninsured Patients/Non-Covered Services</b>	Payment for all charges which are not covered by insurance are due and payable at the time of service. A pre-treatment deposit may be required.
<b>Verification of Information</b>	All information given regarding the ability to pay, third party insurance, employment, etc., will be subject to verification.
<b>Unpaid Insurance Balance</b>	Patients may be requested to make full payment of unpaid balances when insurance payments are not received after 60 days from date of billing.
<b>Third Party Litigation</b>	The physician will not become involved in disputes arising from the third party claims (i.e. automobile accidents, liability claims etc.) with the exception of verified Workers' Compensation claims, or claims involving Medicare and Medical Assistance.
<b>Prior Unpaid Accounts</b>	Prior to providing services, payment of prior outstanding accounts may be requested and should be received or specific payment arrangements are approved by the Credit Department.
<b>Delinquent for Bad Debt Accounts</b>	Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if not medically required.

**Payment Arrangements**

If a patient is unable to make full payment of the patients balance when due, periodic, partial payments may be approved in accordance with credit and collection procedures, as authorized by the physician or his designee. A patient financial evaluation may be requested to determine appropriate payment arrangements.

**Payment Agreements**

When a balance due cannot be paid at the time of service or when the balance becomes due, a payment agreement may be required in order to approve payment arrangements.

**Payment Methods**

The following payment methods will be accepted: Cash, check, money order, and credit card.

**Referral for Outside Collection**

Accounts which cannot be collected by the physician after normal in-house collection procedures may be referred to a collection agency, magistrate, or attorney for further collection action in accordance with the physician's established guidelines.

**Third Party Audits**

The physician recognizes the need for audits of insurance claims by insurance companies or their contracted audit firms. The physician will cooperate in making available required information provided that 95% of covered charges have been paid prior to the audit. An additional fee may be charged based on the costs incurred in providing the requested information and assistance.

**Discounts**

Due to Medicare regulations we are unable to offer any reduced or discounted services.

**Refunds**

Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patient's refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than \$5.00 will not be issued unless specifically requested.

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Patient or Guardian Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date