CREDIT POLICY

This form becomes part of your financial record in this office. We would appreciate your thoughtful consideration.

STATEMENT:

In the interest of good practice, it is desirable to establish a credit policy. An effective credit policy enables the doctor and the patient to avoid misunderstanding. Our primary responsibility is to serve the needs of our patients. We wish to spend our time and energy practicing medicine.

AGREEMENT:

1. The patient (or guarantor if child) is responsible for payment of all medical treatment and other related services provided by Cypress Heart/Kansas Medical Center.

2. As a service and out of consideration to our patients, this office will file insurance claims for all covered services. We will file with up to two insurance companies. If you have additional coverage, we can provide you with the necessary information for you to file yourself. We will not do 3rd party billing.

3. This office will accept your insurance company's maximum allowable reimbursement. The patient will be responsible for any deductible, co-insurance and co-payment amounts. The patient is 100% responsible for payment of any non-covered services at the time of service.

4. Patients with insurance, which requires referral, must have a referral prior to receiving treatment. It is the patient's responsibility to obtain all necessary referrals from the primary care physicians. Patients without proper referrals and electing to receive service from the office will be required to make payments in full at the time of service.

5. An account is considered past due 60 days after service is rendered, unless prior arrangements have been made with our billing office. If no attempted payments have been made, the account will be referred to a collection agency.

6. All accounts that have historically declared bankruptcy or have been turned over to our collection agency may be seen on a cash only basis at the discretion of the physician.

INSURANCE RELEASE:

I authorize payment of medical benefits to Cypress Heart/Kansas Medical Center and agree to release any information requested by my insurance carrier.

I have read and understood the above agreement and by my signature here below, agree to its terms.

_____ _____

Patient Signature/Patient Representative Date

_____

Relationship to Patient