**CARDIOVASCULAR DIAGNOSTICS, PC**

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**MEDICAL ASSOCIATES OF NEW YORK**

**ALL PATIENTS MUST COMPLETE**

**Dear Patient:**

**We value you as a patient and appreciate that you have entrusted us with your health care needs.**

**As you know, there are charges for each of the medical care services that we will provide to you. The copayments, deductibles and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals, but please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits. Since you are ultimately responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a claim for payment should your health plan not honor the claim we submit for services provided to you.**

**Your health benefits, including your responsibility for co-payment, deductibles, and co-insurance is a decision made by your employer, not this office or your health plan.**

**In providing credit card information below, you authorize payment by credit card in the absence of coverage by your health plan (Including, but not limited to, co-payments, co-insurance, deductibles, and or uncovered services).**

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| **Patient's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Payment Method \_\_\_\_ VISA \_\_\_\_ MASTER CARD \_\_\_\_DISCOVER CARD \_\_\_\_AMEX**  **Account Number: \_ \_ \_ \_- \_ \_ \_ \_ -\_ \_ \_ \_ -\_ \_ \_ \_ -**  **Expiration Date \_ \_ - \_ \_ - \_ \_ \_ \_**  **Month Day Year**  **V- Code \_ \_ \_ \_ (3 or 4 digits security code usually on the reverse side of the card)**  **Credit Card Billing Address:**    **Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
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