Denton Cardiology

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Patient Agreement

ASSIGNMENT OF BENEFITS

I hereby allow Denton Cardiology to receive payment of insurance benefits for services provided. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient of the undersigned.

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all services rendered at the doctor's rates. In the event that, insurance benefits are assigned to the doctor and billed to the insurer, I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree that it is my responsibility to obtain any prior approvals required by my insurance provider, and take all other steps to qualify for insurance coverage. I agree that all charges are due upon billing, I agree that if referred to a collection agency or if legal action is necessary to collect my balance, I will be responsible for the doctor's reasonable attorney fees and costs of collection.

NO SHOW AND CANCELLATIONS

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled without a 24 hour notice prior to the allotted time, you will be billed:

- **$25 for office visits and diagnostic testing appointments**

Please be aware that your insurance does not cover this charge. Repeated "no show" appointments may result in referring you back to your insurance company for reassignment to another specialist.

I am aware of the no show and cancellation charges mentioned above. I understand that the office will make every attempt to place a courtesy reminder call for my appointments. However, regardless of whether a reminder call is provided, I am still responsible for attending my scheduled appointments.

BY SIGNING BELOW, I (the patient or patient representative) am obligated to adhere to all the terms set forth herein. This agreement shall remain valid for all subsequent visits and all services after this date unless expressly revoked in writing. I HAVE READ THIS DOCUMENT OR IT HAS BEEN READ TO ME. I UNDERSTAND AND VOLUNTARILY ACCEPT ITS TERMS. IF I AM SIGNING FOR SOMEONE OTHER THAN MYSELF, I CERTIFY THAT I HAVE THE AUTHORITY TO DO SO.

____________________	__________________________	____________
Patient name:	Patient Signature:	Date:

IF THE RESPONSIBLE PERSON IS SOMEONE OTHER THAN THE PATIENT:

The undersigned, individually agrees to be personally responsible for the financial obligations set forth above, and personally guarantees payment of charges.

____________________	__________________________	____________
Name of responsible party:	Signature of responsible party	Date