Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

Patient Agreement in Office Policies

Name: _____ DOB: _____ Medical Record #: _____

Our financial policy has been established to give a clear understanding and prevent any misunderstanding.

I hereby agree to assign payments over to the office of Dr. Viral Lathia. if my insurance carrier does not cover services due to co-payments, deductibles, etc.

I realize that I am responsible for payment(s) of any or of any treatments that my insurance carrier may not pay.

I am responsible for my $ _____ deductible and co-payment which has been determined by my insurance. My co-payment and deductible will be paid at the time of the service, unless other arrangements have been made with the office. If insurance information is incorrect, I will be responsible for the entire payment.

I understand that a $20.00 fee will be charge for all returned/bad checks and will terminate my privilege to pay by check on future visits.

I understand and agree that in the event of any outstanding balance has to be referred to a collection agency or attorney for recover, I will be responsible for all collection and attorney's fees.

Because your time is valuable, we will make every effort to begin promptly. However, our time is equally as important, and we expect that you be on time for scheduled appointments and give us a 24-hour notice of any cancellation(s).

By signing this form, I agree that I have read and fully understand the policy.

X _____ _____

Patient/Guardian Signature Date