MISHKEL HEART & VASCULAR CENTER

1599 NW 9TH AVE #203, BOCA RATON ,FL 33486

YOU ARE RESPONSIBLE FOR YOUR OWN INSURANCE POLICY.

Please read and sign this form as it concerns you, the patient.

Due to the changes in insurance policies, we cannot be responsible for interpreting each individual policy. **It is your responsibility to know your coverage and its limitations, as well as who is a provider for your plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is a contract between you and your insurance company**. It is your responsibility to know or find out whether or not we are providers for your specific network.**

*Referrals

If you need a referral from your insurance company or from your primary care physician, to be seen in this office, the referral must be present at the same time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should a referral not be available.

*Non-participating Provider Policy

If we are not a provider for your insurance company, we will collect our fee in full at the time of service.

*Your Financial Responsibility

You are responsible for payment or any co-payments, co-insurance, deductibles, etc. at the time of service. Because we are specialists, some diagnostic procedures are not considered part of your office visit co-payment and may be applied to your deductible and/or co-insurance. Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out of pocket expense.

*No Show Fee

You are responsible to keep your appointments. As such, if you do not appear for your scheduled office visit you will be charged a minimum of $50.00. Certain procedures have a higher no show fee ; however they are listed separately. We try to confirm all appointments; however, keeping appointments is ultimately a patient responsibility.

Name:_____

Signature:_____

Date:_____