CARDIOVASCULAR WELLNESS

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Notice of Cancellation Policy

Cardiovascular Wellness Specialty Care, P.C. will implement the policies outlined below.

OFFICE VISIT: 24 hours notice is required to cancel an office visit appointment. The following fees will be charged for no show appointments and cancellations with less than 24 hours notice:

New Patient Visit	**$50.00**
Established Patient Visit	**$25.00**
Nursing Visit	**$10.00**

DIAGNOSTIC TESTS: 48 hours notice is required to cancel a procedure appointment. The following tests will be charged for all no show appointments and cancellations with less than 48 hours notice.

Echocardiogram	**$30**	Carotid Doppler	**$30**
Stress Echo / EKG	$50	Lower Extremity	**$30**
Nuclear Stress Test	**$250**	Abdominal Screen	**$30**

DIAGNOSTIC DEVICES: There will be a $25 charge per day for Holter Monitors that are not returned on time. The following fees will be charged for lost or damaged monitors:

Holter Monitor	**$1500**
Compact Flash Card	**$40**

Notice of Payment of Benefits

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I hereby authorize direct payment of medical/surgical benefits to Cardiovascular Wellness Specialty Care, P.C. for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Cardiovascular Wellness Specialty Care, P.C. to release any medical or incidental information that may be necessary for either medical care or financial benefits. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for any collection fees associated with balances on my account. I agree that I am fully responsible for payment for all services rendered to me. If my account is referred for collection I will pay, in addition to the original amount owed, all costs of collection including attorney's fees equal to 1/3 of the debt owed. I understand that if I fail to comply with these polices, I may be subject to the charges outlined above. I also understand that missed appointment charges must be paid before subsequent appointments can be honored.

Patient / Patient Representative Signature: ____

Date: _______________