

Coastal Cardiology, PLLC - Main Suite 102 Clinic

613 Elizabeth Street Suite 102 Corpus Christi, TX 78404 (361) 887-2900 Fax: (361) 887-0942

Ray Graf, M.D., F.A.C.C., F.S.C.A.J. Gregg L. Silverman, M.D., F.A.C.C.

Charles J. Schechter, M.D., F.A.C.C., F.S.C.A.I. Srikanth Damaraju, M.D., F.A.C.C., F.S.C.A.I. Rafael Berio-Muniz, M.D., F.A.C.C. Stephen A. Turner, M.D., F.A.C.C. Shamim Badruddin-Mawji, M.D., F.A.C.C.

FINANCIAL OBLIGATION FOR DIAGNOSTIC TESTING

Coastal Cardiology PLLC is committed to providing the highest level of quality medical care and personal services to our patients. For every commitment there is an obligation. We feel it is the patient's responsibility to meet their financial obligations.

Patient, , has been scheduled by your physician for a Nuclear Stress Test at Coastal Cardiology PLLC. The Nuclear Stress Test requires the use of radioactive materials ordered and prepared in advance for the patient.

If you need to cancel or reschedule your appointment, you will need to notify the Diagnostic Testing Office @ 361-887-2748 or 361-887-2900, option 4 by 12:00 p.m. the day before your scheduled testing date. Failure to contact the Diagnostic Testing Office will result with the patient being responsible for a charge of \$115.00. This charge is the cost of the radioactive materials that is unusable therefore discarded when patient does not show up for the test. This charge will not be billed to patient's Commercial, Medicare, or Medicaid insurance.

In addition, if patient does not follow the instructions given prior to the patient at time of scheduling, specifically refrain from any caffeine products 12 hours prior to the patient's appointment, patient may be liable for the fee of \$115.00

I have read the above Financial Obligation Policy for the Nuclear Stress Test and agree to be charged a fee of \$115.00, if I fail to abide by the Financial Obligation Policy.

I give my permission to Coastal Cardiology PLLC to process the fee of \$115.00 onto my Visa/ Master Card/ Discover/American Express or Check.

Patient Name	Signature of Patient
Date	Witness