FINANCIAL POLICY

NOTICE: The last several years have been a time of profound change regarding healthcare medical billing and due to this East Valley Cardiology will be implementing section one (1) below **Effective 10/01/2023,** all other sections are current policies followed by East Valley Cardiology.

PLEASE READ AND SIGN

1. East Valley Cardiology is committed to properly identifying patient responsibility for services performed prior to services rendered. We will make every effort to communicate to patients their anticipated patient responsibility prior to the appointment but no later than at the time of service. Though East Valley Cardiology will make every effort to assist patients with benefit details, patients are responsible for understanding the coverage and benefits of their insurance plan. Patients will be responsible for paying any deductible, copay, or the coinsurance percent at time of service. Please be prepared with the following payment methods; we accept Visa, Mastercard, Discover, American Express, cash and checks.

2. We understand financial hardships may occur. We will make every effort to assist patients with payment arrangements for any patient responsibility anticipated for services rendered. Our billing department can be reached at (480)899-9430 Opt. 4 to assist you with setup of payment plan agreement.

3. Cash-Pay patients: this includes patients with no insurance and/or patients who choose to undergo services at a cash pay rate. At time of scheduling the office will make every effort to provide you an estimate of cost. Payment for medical services is required the day of your scheduled appointment, if a payment arrangement is needed this will need to be established prior to services being rendered. Our billing department can be reached at (480)899-9430 Opt. 4 to assist you with setup of payment plan agreement.

4. HMO or PPO Patients Requiring a Referral: You are responsible for making sure your visits with our office are authorized by your Primary Care Provider. **This authorization must be obtained prior to your scheduled appointment with our office.** It is the patient's responsibility to make sure we have received authorization. If referral is not received, we will have to reschedule your appointment.

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5. If your insurance denies payment on your claim due to a coordination of benefits, termed plan coverage or services not covered under your plan benefit, our billing department will make every effort to work **with the patient** to resolve claim with insurance, if possible. If insurance final determination remains unchanged, the balance will be placed to patient's responsibility, and patients will be responsible for payment of services received.
6. In accordance with AMA CPT guidelines, we reserve the right to charge for telephone calls with our providers that included evaluation and management of your medical condition. We will bill your insurance for such calls but if it is not covered by your insurance, you may be responsible for the charges.
7. Your account must be in good standing before you receive medical treatment. If you are needing to set up a payment agreement for services and/or a past due balance, please contact the billing department and they can assist. Payment Plans are available at our office, these are set up as automatic payments to be ran on an agreed specified date. Our billing department can be reached at (480)899-9430 Opt. 4 to assist you with setup of payment plan agreement.
8. If a patient has a balance that is more than 90 days past due, we may deny scheduling of either an office visit or testing till the balance is either paid in full or a payment agreement has been set up. It is the patient's responsibility to make sure that their balance is paid in a timely manner. Should your account become delinquent you agree to reimburse East Valley Cardiology of any fees we may incur in our attempt to collect a debt which may include but not limited to costs, court fees and expenses, including reasonable attorney's fees.

AS A FINAL NOTE:

Remember, you and/or your employer pay the monthly insurance premiums to your insurance carrier. This means that the insurance company is accountable to you. Do not hesitate to contact them if you disagree with their processing or payment of your claim or to find out the status of your claim.

If you have any questions regarding this financial policy, please contact the billing department.

I have read this information and agree with this policy.

Signature:_____ Date:_____

Please use blue/black ink

PATIENT NAME: _____

DOB: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

East Valley Cardiology follows the guidelines as stated in our Notice of Privacy Practices. Please acknowledge by signing below that you have been, offered or provided a copy of East Valley Cardiology's *Notice of Privacy Practices.*

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of photocopies of the following medical records and/or x-ray films in the possession or control of East Valley Cardiology, LTD, its employees and/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" and "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 (FR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREAMENT INFORMATION.

I authorize the release of medical information to the entities indicated below. I understand that confidentiality cannot be guaranteed.

Physicians:
Family Members (please list name and relationship):
Can we contact you using the following personal electronic devices? Voicemail or Answering Machine: YES NO Fax: YES NO (if yes, fax number)_____ Email: YES NO (if yes, address)_____

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

I authorize release of all medical information that is pertinent to my medical care and necessary to process my insurance claims. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to East Valley Cardiology, LTD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for all charges. In the unfortunate event that an account is given to a collection agency or to an attorney, for collection, then the patient/responsible party shall pay to East Valley Cardiology all costs of collection, including reasonable attorney's fees and court costs, in addition to other amounts due East Valley Cardiology. I have read this information and agree with this policy.

I have read and understand the PRIVACY PRACTICES, AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/FINANICAL AGREEMENT contained herein.

Patient Signature:_____ **Date:**_____