FINANCIAL POLICY

Patient Name (please print)_________________________________ **Date of Birth:** __________

Thank you for choosing CVMG as your Cardiology/I.M. provider. We are committed to providing you with quality and affordable health care and ensuring that your treatment is successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Payment Policy and explains your financial responsibilities. Please read it, let us know if you have any questions, and sign below.

All patients must complete our "Patient Information Form" prior to seeing the doctor.

1) **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, checks, American Express and Visa/Mastercard. If your referring physician has indicated an alternative payment plan please take the time to notify the business office representative. This will greatly alleviate any potential confusion, and ensure that your account remains current. **Please Initial:_____**

2) **Insurance.** If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance does not pay your claim within 45 days, the balance will be your responsibility. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. For those with two or more private insurance plans, we will bill only your primary insurer.

3) ***I request that payment of authorized Medicare and/or other insurance company benefits be made to CVMG on my behalf for any services furnished to me by CVMG. I authorize any holder of medical information about me to release any information needed to determine those benefits to pay for related services. Please Initial:_____**

4) **PPOs.** We are enrolled in various PPO programs; please check your insurance provider booklet to see if we are members of your specific plan. If we are not, you will be responsible for the balance not covered by your insurance plan, regardless of the insurance company's determination of usual and customary rates. If we are members, you will only be responsible for non-covered services, copayments and deductibles. **Please Initial:_____**

5) **Medicare**. Our medical group accepts Medicare assignment. This means that you will be responsible for copayments and deductible, and that the difference between what we charge and what Medicare approves will be written off. If in the event that you have a secondary carrier, you will only be responsible for the deductible if your secondary carrier does not pay the Medicare deductible. Recent Federal Legislation has made it illegal for physicians to routinely write off copayments and deductibles. **Please Initial:_____**

6) **Advance Beneficiary Notice or Waiver of Liability (Non-Covered Services).** Medicare or your Insurance may not pay for all your healthcare services. They may pay only for covered services. The fact that they will not pay for a particular service does not mean that it is not medically indicated. There is good reason why your physician recommended it. You will be informed on how much these services many cost and be asked to sign the waiver of liability forms.
Please Initial:_____

7) **Claim submission.** We cannot bill your insurance unless you bring in all insurance information. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.
Please Initial:_____

8) **Insurance Cards.** Photocopies of the front and back of all insurance cards must be maintained in our business office at all times. If you see the doctor and do not provide us with complete insurance information, your account will be assigned a cash status, and payment in full will be required at the time of the visit. **Please Initial:_____**

9) **Authorization to release information.** CVMG physicians and staff may give out written or verbal information concerning my medical records to any insurance carrier or agent that is authorized to have access to and make copies of my medical records. **Please Initial:_____**

10) **Self Pay.** Self pay patients are required to pay 100% fee for service at time of visit.
Please Initial:_____

11) **Nonpayment.** If your account is over 60 days past due, you will receive a letter stating you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collections agency. Should the account be referred to an attorney or collection agency, the undersigned agrees to pay the actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. **Please Initial:_____**

12) **Missed appointments.** It is important to give us at least 24 hours notice if you will not be able to make an appointment. You will be charged if cancellation does not occur within 24 hours (weekday) of your appointment. Office Visits $35.00/ Consults $75.00/ Special Procedures $100. All special procedures requiring contrast material will be charged at a rate of $250.00 if not given a 24 hours notice. ***Please Initial:_____***

13) **Special letters and Healthcare related form completion.** Any requests for a letter describing any medical conditions and/or treatments will be charged at a rate of $35.00.
Please Initial:_____

14) **Copy of medical records, echo tapes, CD copies.** Any request for copy of medical records is $35.00. Echo tapes or CD copies will be charged $25.00 each. Storage retrieval of Medical Records is $35.00. **Please Initial:_____**

ACKNOWLEDGEMENT OF RECEIPT OF
CARDIOVASCULAR MEDICAL GROUP OF SOUTHERN CALIFORNIA (CVMG)
NOTICE OF FINANCIAL POLICIES

By signing this document, I acknowledge that I understand and agree with CVMG's Financial Policies

Name (printed):______________________________ Date: ____________

Signature: ____