

VITAL HEART & VEIN PATIENT FINANCIAL AGREEMENT

The purpose of this document is to inform our patients of their personal responsibilities under the current financial policies of Vital Heart & Vein. We encourage you to ask any questions you may have about this financial agreement, as your understanding of our financial policies is an important part of your overall experience with our office. Please read the agreement carefully and then acknowledge your understanding by signing in the space provided.

OUR RESPONSIBILITY TO YOU:

- To keep up-to-date records of your insurance coverage and personal demographics.
- To make a good faith effort to contact your insurance carrier in advance to obtain any required pre-certifications, referrals, and/or authorizations along with the details of your insurance benefits.
- To define and communicate to you in advance any out-of-pocket expenses you may incur while receiving your care from our office. Please be aware that this will be an estimate based upon the information provided to us by your insurance company and not a guarantee of the actual results. We encourage you to call your insurance carrier in advance to make sure that you fully understand the benefits provided by your policy.
- To submit medical claims (excluding Workman's Comp, Auto Claims) to your insurance carrier on your behalf and to make appropriate appeals when claims are initially denied by your insurance carrier.
- To provide you with an itemized statement of any balances that drop to patient responsibility and to be available to answer any questions you may have about your statements.

YOUR RESPONSIBILITY TO OUR OFFICE:

- To provide accurate and up-to-date insurance and personal demographic information to our office. The failure to provide us with this information may lead to the unnecessary denial of your claims and result in you being held personally responsible for the outstanding balance.
- If your insurance carrier is a Health Maintenance Organization (HMO), to obtain the required visit referrals from your primary care provider.
- To call your insurance carrier prior to your date of service to verify that your physician is considered an in-network provider and that any required pre-certifications, referrals, or authorizations have been obtained.
- To come to our office on the date of service prepared to pay the quoted out-of-pocket expenses. We reserve the right to reschedule or cancel your service if you are unable or unwilling to pay the quoted amounts.
- To pay any balances dropped to patient responsibility after the adjudication of your claim by your insurance carrier. Depending on your individual insurance coverage and benefit status, these balances may include copayments, deductibles, and co-insurance. As per our contractual relationships with the various insurance carriers, it is our responsibility to make every reasonable effort to collect these balances up to and including the use of external collection companies.

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SELF-PAY PAYMENT POLICY:

- Vital Heart & Vein will provide you in advance with a quoted amount to cover all of the services provided on your date of service.
- Payment in full is due and payable at the time the services are rendered. Vital Heart & Vein reserves the right to reschedule or cancel your services if you are unable to make the quoted payment.

NO SHOW AND CANCELLATION POLICY

- Please note that it is essential that you notify our office in advance if you need to miss your scheduled office visit or testing appointment for any reason. This notification is necessary in order to allow us adequate time to attempt to schedule another patient in that time slot. A missed appointment is a missed opportunity for another patient and results in increased wait times for all of our patients.
- For office visits, please notify our office at least 24 hours in advance. We will be happy to reschedule your appointment at that time. On your second no-show or late cancellation, there will be a \$45 cancellation fee charged to your account. After a third occurrence, we cannot guarantee the time frame for rescheduling your appointment.
- For testing appointments, the required cancellation period is 48 hours in advance. These testing slots are limited and often require us to purchase the testing materials in advance. Any no-show or late cancellation will result in a cancellation fee being charged to your account. The cancellation fees are as follows:

Echo/Ultrasound Scan	\$75
Nuclear/Stress Test	\$200
CT Scans	\$200

Signature

Date