



TREATMENT & PAYMENT POLICIES

Thank you for choosing CARDIOVASCULAR ASSOCIATES, LTD for your health care services. We believe the physician-patient relationship is strengthened when there is a clear understanding between both parties about their rights and obligations. CARDIOVASCULAR ASSOCIATES, LTD. is a private organization, and as such we do not receive assistance from state or federal programs to cover the costs of services provided to our patients. We rely solely on income from patients and their insurers. To provide you with the best possible medical care at the lowest cost, we need your assistance and agreement to our payment policies. Please review and sign the following statement about our TREATMENT AND PAYMENT POLICIES prior to receiving treatment. If you have any questions about our TREATMENT AND PAYMENT POLICIES please do not hesitate to ask.

TREATMENT POLICY:

I agree and understand that:

- CARDIOVASCULAR ASSOCIATES, LTD. physicians, physician extenders (nurse practitioners and physicians' assistants), clinical and technical employees may administer any treatment or perform any procedures deemed advisable in my care and treatment;
- I will have the opportunity to discuss proposed procedures and therapeutic courses of treatment with the physician or health care professional;
- I have the right to consent or refuse any proposed procedure or therapeutic course of treatment;
- In the event of an exposure of a CARDIOVASCULAR ASSOCIATES, LTD. employee to my blood or body fluids in a manner that may, according to current guidelines of the Center for Disease Control, transmit HIV (human immunodeficiency disease virus), Hepatitis B virus, or Hepatitis C virus, I consent to testing of my blood and/or body fluids for these infections. I also agree to the release of test results to the employee who was exposed. I understand I will be offered the opportunity for face-to-face disclosure of these test results and counseling.

PAYMENT POLICY

I agree and understand that:

- By signing this document, I agree to assign to CARDIOVASCULAR ASSOCIATES, LTD. any and all health care benefits that I am entitled to under any policy of insurance (hospitalization, major medical, workers' compensation, or any other insurance or benefit plan) and authorize, to the extent permitted by law, payment of those benefits directly to CARDIOVASCULAR ASSOCIATES, LTD. By signing this document, I also authorize the release to insurance carriers or other third party payors or their agents, any medical information which may be necessary to determine coverage or which may be required for utilization and quality review, utilization management, or continuing care oversight.
- CARDIOVASCULAR ASSOCIATES, LTD. will submit a claim to my insurance carrier on my behalf. However, I understand and agree that I am required to pay at the time of service any required co-payments, co-insurance and deductibles, as well as charges for services not covered by my insurance. I understand that I can make this payment with cash, personal check, or credit card. I agree to pay a \$20.00 fee for returned checks.
- CARDIOVASCULAR ASSOCIATES, LTD. allows more than the legal and customary amount of time after filing a claim to be reimbursed by insurance carriers. If CARDIOVASCULAR ASSOCIATES, LTD. has not received a response within 30 days of having filed a claim for a visit, they will assume that the visit is not covered and is, therefore, my responsibility. At that time, to the extent permitted by law, CARDIOVASCULAR ASSOCIATES, LTD. will bill me for the visit charges. I understand that if I have questions regarding non-payment by my insurance carrier, I may call a CARDIOVASCULAR ASSOCIATES, LTD. patient representative at (757) 499-2825 for assistance in contacting my insurance carrier to resolve this matter. I also agree that I will promptly respond to requests from my insurance carrier for additional information, in order to speed up their processing of my insurance claim.
- In the event that my insurance plan requires approval or referral from my Primary Care Physician (PCP) or insurer to a visit and I did not obtain that approval or referral, I will agree to sign a REFERRAL WAIVER that explains my financial responsibility for the visit.
- I understand and agree that I am responsible for paying my bill in full unless special arrangements have been approved in advance by speaking with the patient financial counselor at the medical office where I received treatment or calling a patient accounts representative at (757) 499-2825.
- In the event of a default on any payment due CARDIOVASCULAR ASSOCIATES, LTD., I agree to pay all costs of collection including attorney's fees equal to 33 $\frac{1}{3}$ % of the amount due and court costs.

Patient _____ Date _____

Guarantor(if not Patient) _____ Date _____

MEDICARE & CHAMPUS PATIENTS: PLEASE COMPLETE LIFETIME AUTHORIZATION

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine benefits or the benefits payable for related services.

Patient/Guarantor _____ Date _____