Premier Cardiology & Vascular Associates

Changing Lives Everyday

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Notice of Office and Financial Policies Acknowledgement Form

Welcome! We are pleased that you have chosen Premier Cardiology & Vascular Associates for your specialty healthcare needs. We would like to familiarize you with our office and financial policies. It is our belief that the best service is only possible when there is a mutual understanding between you and the practice regarding our policies. We ask that you take the time to read our policies so that we can avoid misunderstandings. If you have any questions, we will be happy to discuss them with you.

- If you are experiencing an emergency, please call 911
- You must call 24 hours in advance and on Friday's for Monday appointments to cancel an appointment or a no show fee will be charged to your account
- The No-Show fee is $40
- Copay's and deductibles are due at the time of the visit. Please check with your insurance carrier for details on your specific benefits by calling the customer service number on the back of your insurance card
- We will attempt to provide you an **estimate** of cost for your services. However, please note that this is only an **estimate** and the final billable charges, as well as patient responsibility, can only be determined after the claim has been filed with the insurance company for services rendered. Every patient's policy is different and therefore, there is not a single answer to the question "How much will this service or procedure cost me?"
- If you need a payment plan/schedule, please ask to speak to a billing representative and we will be happy to arrange something for you
- Payments for services which have been billed to you are due within 30 days of receipt or per the agreed upon payment schedule. If you fail to pay within a reasonable amount of time or per the agreed up schedule, your account may be turned over to an outside collection agency for resolution
- Messages are typically returned within 24-48 hours of your call. If you call to speak to one of the clinic staff, please be sure to leave a message as they are likely with patients. This way, your questions/concerns can be addressed as soon as possible
- **Medication refills will require 72 hours to be completed.** Patients are required to see the healthcare provider on a regular basis in order to qualify for medication refills. Patients who are unable to keep scheduled appointments may be granted a refill for a limited supply of

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medications. Failure to keep appointments after this may result in the denial of additional refill requests.

- If your pharmacy is faxing refill requests, it is your responsibility to ensure that they have the accurate fax information for this office.

- Paperwork or other documentation will require **at least 1 week** to be completed. Please take this time into consideration when paperwork needs to be completed by the office staff.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **Premier Cardiology & Vascular Associates** now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by **Premier Cardiology & Vascular Associates**, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance.

I agree to immediately remit to **Premier Cardiology & Vascular Associates** any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to **Premier Cardiology & Vascular Associates**. I authorize **Premier Cardiology & Vascular Associates** to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to **Premier Cardiology & Vascular Associates** and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by **Premier Cardiology & Vascular Associates**, now, in the past, or in the future. I also authorize **Premier Cardiology & Vascular Associates** to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

By signing this form, you agree to the terms listed above and acknowledge that you understand and are aware of the policies of the office.

Patient Name (Print): _____

Signature: _____

Date: _____

Witness: _____