Heart & Vascular
Financial Policy

In compliance with the Federal Consumer Protection Act, *Polk Cardiovascular Services*, is furnishing you with information regarding your financial responsibilities. Welcome! We are pleased you have chosen *Polk Cardiovascular Services* for your health care needs. We'd like to familiarize you with how our services are billed, which we request payment from you and our credit policies. It is our belief that the best services is possible when there is a mutual understanding between you and the physician. We ask that you take the time to read our policy so that we can avoid any misunderstandings. If you have any questions our billing department will be happy to discuss them with you.

INSURANCE

Polk Cardiovascular Services participates in Medicare, Medicare HMO, most of the PPO and HMO plans, and straight Medicaid. ALL COPAYS ARE DUE AT THE TIME OF SERVICE. If you have an indemnity plan (80/20) and your deductible has been met, we will file for you. You will be responsible for you 20% at time services are rendered. If your deductible has not been met, payment is required at time of services. After 45 days all unpaid balances will be transferred to your responsibility. Please direct questions to a billing representative.

Note: Even though we participate in your insurance program, some charges, may also be your responsibility. It is always your responsibility to make sure appropriate authorization has been obtained for procedures and/ or hospitalization when necessary. If your insurance company refuses to pay services due to a lack of an authorization you will be responsible for these non-covered charges.

It is always your responsibility to understand the coverage your insurance program provides and its referral authorization process. Please understand that our office cannot accept responsibility for payment on your insurance claims. Questions about coverage and benefits are between you and your insurance company. For Patients not covered under any billable plans, we require payment at the time of service.

BILLING

We will furnish you with a monthly statement or your account showing the amounts billed to you and any payments received on your account. This monthly billing will also provide you with a detailed aging of how long balances have been outstanding. Payments can be made in cash or by check from local bank. We accept Master card, Visa, American Express or Discover.

CREDIT POLICY

In cases of hardship we may agree to set up a payment schedule for patient balances due. All payment plans are arranged upon reviewing each case. Please discuss with the billing agency regarding the payment arrangements if it is necessary.

COLLECTION POLICY

Payments for services which have been billed to you are due in full within 30 days of receipt of your billing statement. If you fail to pay within a reasonable amount of time or cooperate with the terms of an agreed upon payment schedule, your account may be turned over to a collection agency for resolution.

REFUND POLICY

If your account has a credit balance, any overpayment to your accounts will be refunded to you. If there is a outstanding balance due on your account all credits will be applied to that balance prior to issuing a refund. Please notify us if there is a change in NAME, ADDRESS, PHONE NUMBER or INSURANCE COVERAGE, to avoid problems due to delayed mail .

NAME: _____ SIGNATURE: _____ DATE: _____

FINANCIAL AGREEMENTS

Our Financial services are rendered to you, not the insurance company. Payment for the treatment is your responsibility.

____ I have no insurance coverage. I understand that I am responsible for payment of services rendered to myself at the time of service.

____ I understand if I fail to pay amounts owed; the clinic has the right to secure an outside collection agency and/or attorney to collect unpaid debt, and to report debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

INSURANCE AUTHORIZATION AND ASSIGNMENT

____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered t my dependents or myself.

____ I understand that I am responsible at the time of service for paying any required co-payment and deductible.

MEDICARE/MEDIGAP PATIENTS

For Medicare Patients Only **_____**
Medicare Number

____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of the health care provider of any other party who accepts assignment. I understand it is mandatory to notify the heath care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Medigap Authorization Statement **_____**
Policy Number

____ I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

THERE WILL BE $ 25 CHARGE ON ALL RETURNED CHECKS.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY

_____ _____
Patient/Parent/Guardian **Date**

Please present both your insurance card and your driver's license so we may make a copy for our records.

I will be paying by _____ Check _____ Cash _____ MC/Visa/Discover/American Express