Gainesville Heart and Vascular Group Patient Financial Policy

We require that you read and sign this financial policy. This policy is effective 10/15/12. In this agreement, the words "you," your,", and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Gainesville Heart and Vascular Group, P.C.. It is the policy of this office to help keep your healthcare costs as low as possible. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office.
- If your plan requires a referral or authorization, please bring it with you to your appointments.
- Please notify us at time of check-in of any changes in insurance, address, telephone or family status.
- Please pay your co-pay, co-insurance and/or deductible at the time of service.
- You will be expected to pay in full if:
  - You do not have insurance
  - If a referral or authorization for your visit is not on file
  - Gainesville Heart and Vascular Group does not participate with your health plan,
  - You are unable to present a valid member identification card from your insurance carrier at your visit, or
  - We are unable to verify your insurance coverage
- You should receive a bill for any other patient responsibility within 30 days; and/or an explanation of benefits (EOB) from your insurance company.

1. Statements: If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. Please be aware if you do not receive a statement the balance is still due. If you do not receive a statement but believe you have a balance, please contact the billing department at (770) 534-9014.
2. Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days.
3. Payment Options if you have Insurance: We are required by our insurance contracts to collect co-pays and other patient responsible amounts, at the time of service. Any co-pays that are not paid on the day of the visit may be subject to a $25.00 co-pay processing fee. To assist you, we accept cash, checks or credit cards.
4. If you have not met your deductible: we will estimate the expected insurance payment for your visit and request that amount at the time of service. This is an estimate only. You may receive a statement with additional balances after your visit.
5. Payment Options if you have No Insurance: Unless arrangement are made in advance, we will collect payments at your visit. Your choice is to pay by cash, check or credit card on the day that treatment is given. Any unpaid balance remaining from your visit will incur a $25 billing charge.
6. Insurance: It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, we suggest that you verify coverage limitations prior to being treated. Although we will estimate what your insurance company may pay for your visit, it is the insurance company that makes the final determination of your financial obligation and eligibility for services. You agree to pay any portion not covered by your insurance company. If your insurance company has not processed your claims within 90 days from the date of service, the balance may automatically be sent to you. Your signature on this form indicates that you authorize Gainesville Heart and Vascular Group, PC to bill your insurance company directly for services rendered and for your insurance company to make payment directly to Gainesville Heart and Vascular Group, PC.
   a. MEDICARE PATIENTS: SIGNATURE ON FILE- I request and authorize payments of Medicare benefits be made to Gainesville Heart and Vascular Group, PC. for any services furnished me by the listed provider/supplier. I authorized any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or their approved claim forms or electronically submitted claims, my signature authorizes

the release of all information to the insurer as necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, coinsurance, and any non-covered services.

7. Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. Any balance past due by 30 days may accrue interest at the rate of 1.5% per month or 18% per year. If we have to refer your account to a collection agency, you agree to pay all of the collection costs including a collections fee that may be added to the account. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees that we incur, plus all court costs. **If we need to send the account balance to collection because of non-payment of the account, our physicians may no longer be able to provide care. In this case, the person responsible for the account will be notified of this by certified mail and given adequate time to find a new medical provider.** All accounts sent to the collection agency will be reported to the Credit Bureau and may be subject to a collection fee of $50 in addition to all other collections and/or attorney fees.
8. Insurance Release: I understand that my health plan may not be liable for service rendered if any of the following conditions apply:
    a. I have a pre-existing condition or other diagnosis that may not be covered by my plan;
    b. Gainesville Heart and Vascular Group, PC., does not participate in my health plan;
    c. I have not met the deductible under my health plan contract
9. On the Job Injuries/Accidents: If the reason for your visit is an accident or injury while on the job, please know that we will submit the bill directly to your employer or your employer's workers' compensation carrier- the bill will not be covered unless your employer files a claim to the carrier-it will remain your responsibility until a valid claim is filed by your employer.

Additional Fees

10. **Unpaid Copays**: Any co-pays that are not paid on the day of the visit may be subject to a $25.00 co-pay processing fee. ***Initial:*** __________________
11. **Returned checks:** There is a fee of $30.00 for any checks returned by the bank. This amount may change. ***Initial:*** ________________
12. **Forms:** There may be a charge for the office to fill out any form. The cost will be $25 per form. ***Initial:*** _________
13. **Copies and Transfer of Records:** A nominal fee is assessed to cover copy costs. ***Initial:*** _________
14. **Cancellations:** Patients who are scheduled to see a physician or midlevel and/or scheduled for specialized tests, have extended time and/or medication that has been scheduled and/or ordered specifically for them and do not cancel within 24 hours of their appointment, may be charged a $25 "No Show" fee. ***Initial:*** _________
15. **Collection Fees:** Interest may be charged on past due accounts of 1.5% per month. Collection fees of $50 may be charged in addition to other fees. See section 7 above for more details. ***Initial:*** _________
16. **Billing Charge:** If you are a patient with no insurance and you do not pay your total bill at the time of your service and have not made other arrangement, you may be assessed a $25 billing charge. ***Initial:*** _________

17. Effective dates: Once you have signed this agreement, you agree to all of the terms and conditions contained herein for this and any future visits, and the agreement will be in full force and effect.

I have read this Patient Financial Policy, as outlined, and understand that I am ultimately responsible for the charges incurred by me.

By executing this agreement, you are agreeing to pay for all services that are received.

___________________________________ ____________________

Patient Name Account Number

____________________________________ _____________________

Patient/Guardian Signature Date

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Guardian Name (Printed) if different than patient.