Financial Policy and Patient Responsibility

We are committed to providing our patients with the highest quality care.
Thank you for taking the time to read and understand our policy.

Healthcare Providers and Patients have a unique relationship with insurance carriers and different sets of responsibilities.

It is the **Patient's** Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage prior to their appointment regarding such items as contracted physicians with their plan, covered and non-covered benefits, authorization requirements, deductibles, coinsurance and co-pays. We recommend you contact your carrier directly with any questions pertaining to your coverage.
- To obtain a referral from their Primary Care Physician (PCP) prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-pay, deductible and coinsurance at the time of service.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To pay any balance due as a result of non-disclosure of any health insurance coverage.
- To facilitate claims payment by contacting their insurance carrier when claims have not been paid.
- To understand that as a courtesy, CVAM will file claims with a secondary or tertiary insurance carrier one time. Payment and/or follow up on balances due by a secondary or tertiary insurance are the patient's responsibility.
- To be held responsible for any return check fees.
- **To cancel an appointment at least 24 hours in advance. Failure give a 24-hour time notice may result in the assessment of a no-show fee: $25 for an established patient office visit, $50 for a new patient office visit, $100 for a nuclear test and $50 for all other types of testing. Failure to arrive for scheduled appointments can affect your medical care as well as our Providers ability to treat you. Patients who no show 3 consecutive appointments are at risk of being discharged from our practice.**
- To pay a $25 administrative fee or to make an appointment with the provider, when requested by the provider, for the completion of forms such as FMLA, Disability and other forms requiring manual completion. Payment is required in advance and is not billable to your insurance carrier.
- To understand that CardioVascular Associates of Mesa does not allow electronic recording within the building.

It is the **Provider's** Responsibility:

- To file insurance claims on the patient's behalf. CVAM will file a claim with primary carriers. As a courtesy to our patients, secondary and tertiary claims will also be filed one time. A 60-day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.
- CVAM, its physicians and employees are not responsible for providing insurance coverage and benefit information to patients. As a courtesy, the CVAM Billing Department is available to assist you with your questions.

CardioVascular Associates of Mesa, PC may release any information regarding my medical condition and treatment to my insurance company. I assign all insurance benefits to CVAM. I understand I am responsible for any and all charges. I agree to pay any balance unpaid by my insurance company. This authorization will remain in effect until revoked by me in writing.

I have read and understand the above financial policy. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

Patient Name (please print): _____

Signature: _____ Date: _____

HIPAA Privacy Policy

CVAM, CardioVascular Associates of Mesa, P.C.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you have access to this information. Please review it carefully. If you have any questions about this notice, please contact our Privacy Officer or our Compliance Officer at 480-641-5400.

This notice describes the privacy practices at our office.

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of the notice currently in effect

How we may use and disclose your health information

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer or Compliance Officer.

Treatment – We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment – We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations – We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities such as appointment reminders, treatment alternatives, and health-related benefits and services. When appropriate, we may share your health information with a person involved in, or paying for your care (such as a family member or significant other). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research – We may disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research as long as they do not remove or copy any of your health information.

As Required by Law – We will disclose your health information when required to do so by international, federal, state or local law. To Avert a Serious Threat to Health or Safety – We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates – We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans – If you are a member of the Armed Forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Workers' Compensation – We may release your health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks – We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities – We may disclose your health information to an agency who oversees health activities for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes – If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement – We may release your health information at the request of a law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors – We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities – We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody – If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care; 2) to protect your health and safety or that of others; and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy – You have the right to inspect and copy your medical and billing records by written request to our Privacy Officer or Compliance Officer.

Right to Amend – You have the right to request an amendment to your records by written request to our Privacy Officer or Compliance Officer. If CardioVascular Associates of Mesa believes the record is correct, you still have the right to have your disagreement noted in your file.

Right to an Accounting of Disclosures – You have the right to an accounting of certain disclosures by written request to our Privacy Officer or Compliance Officer.

Right to Request Restrictions – You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to our Privacy Officer or Compliance Officer. We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication – You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to our Privacy Officer or Compliance Officer. We will accommodate reasonable requests.

Right to File a Complaint – You have the right to file a complaint if you believe your information was used or shared in a way that is not allowed under the privacy law, or if you were not able to exercise your rights. You can file a complaint with our Privacy Officer or Compliance Officer or your health insurer. You may also file a complaint with the U.S. Government.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have on file as well as new information. The current notice will be available at all times. You have the right to request a paper copy of the current notice at any visit or by written request to our Privacy Officer or Compliance Officer at:

CVAM
6116 East Arbor Avenue Suite 112
Mesa, Arizona 85206

6116 E Arbor Ave Bldg 3, Ste 112, Mesa, AZ 85206
2730 S Val Vista Dr Bldg 8N, Ste 140, Gilbert, AZ 85295
2979 W Elliot Rd Bldg 5, Ste 112, Chandler, AZ 85224
37100 N Gantzel Rd, Ste 202, Queen Creek, AZ 85140
P (480) 641-5400 F (480) 218-4353

Notice and Acknowledgement of Receipt of Privacy Policy – HIPAA

Acknowledgement:

I acknowledge that I have received CardioVascular Associates of Mesa's Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature Date

_____ _____

Patient or Personal Representative Print Date

If signed by a Patient Representative, state relationship to patient _____

You have the right to request restrictions or limitations on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care by written request.

I hereby request the **nondisclosure** of my health information to the following individual/entity.

_____ _____

Name Relationship

_____ _____

Patient or Personal Representative Signature Date

6116 E Arbor Ave Bldg 3, Ste 112, Mesa, AZ 85206
2730 S Val Vista Dr. Bldg 8N, Ste 140, Gilbert, AZ 85295
2979 W Elliot Rd. Bldg 5, Ste 112, Chandler, AZ 85224
37100 N Gantzel Rd, Ste 202, Queen Creek, AZ 85140
P (480) 641-5400 F (480) 218-4353

Release of Information (ROI) to Spouse / Significant Other / Family Member

This authorization grants permission to the person named below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis and treatment plans; and have access to my financial health information.

Patient Name: _____

Date of Birth: _____ MRN # (staff use) _____

Authorized Individual: _____

Relationship to patient: _____Telephone: _____

Authorized Individual: _____

Relationship to patient: _____Telephone: _____

Authorized Individual: _____

Relationship to patient: _____Telephone: _____

□ I give my permission for CVAM to leave messages on my voicemail and/or answering machine.

□ I do not give my permission for CVAM to leave messages on my voicemail and/or answering machine.

I hereby authorize CardioVascular Associates of Mesa, PC to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to the party named above the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying CardioVascular Associates of Mesa, PC in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by CardioVascular Associates of Mesa, PC prior to their receipt of the revocation.

I understand that my treatment cannot be conditioned on whether I sign this authorization.

Patient Signature: _____

Date: _____

Medical Records
Phone: (480) 641-5400
Fax: (480) 218-4353

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient Name:_____ Previous Name (If Applicable)_____

   Address: _____City:_____State: ____Zip Code: _____

   Phone#:_____Date of Birth: ____/____/____SSN:_____ CVAM Medical Record#:_____

I authorize CVAM to: Request / Release (*Circle One*)
Healthcare Information of the patient named above from / to:

2. Name (Physician/Hospital/Family Member/Self)_____

   Address: _____Suite#:_____

   City: _____State:_____Zip Code: _____

   Phone#:_____Fax#: _____

   For the purpose of: _____

   Preferred Format: Paper / Electronic CD (*Circle One*)

3. **The type and amount of information to be disclosed is as follows (*specify dates where appropriate)***
   - o Complete Medical Record
   - o Complete Medical Record from date, _____to date_____
   - o Laboratory Results from date, _____to date_____
   - o Billing Information_____
   - o Other_____

4. **I understand that the medical information released by this authorization may include confidential information concerning treatment of physical and/or mental illness, alcohol/drug abuse, HIV/AIDS and past medical history.**

5. **I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.**

6. **I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. CVAM cannot condition treatment, payment, enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.**

_____ _____
Signature of Patient or Authorized Personal Representative Date

_____ _____
Patient or Personal Representatives Name (print) and Relationship Date
(Please attach applicable legal documentation of authority)

FOR OFFICE USE ONLY:

Photo ID Verified by: _____ _____
Name Date

6116 E Arbor Ave Bldg 3, Ste 112, Mesa, AZ 85206
2730 S Val Vista Dr Bldg 8N, Ste 140, Gilbert, AZ 85295
2979 W Elliot Rd Bldg 5, Ste 112, Chandler, AZ 85224
37100 N Gantzel Rd, Ste 202, Queen Creek, AZ 85140
P (480) 641-5400 F (480) 218-4353

In order to serve you better please provide us with your most current updated information:

PLEASE PRINT

Patient Name: _____

Date of Birth: ___/_____/____

Primary Care Physician

Primary Care Physician Name:
Address:
Telephone:
Fax Number:

Pharmacy Information

Local Pharmacy:	Mail Order Pharmacy:
Major Crossroads:	90-Day supply may be filled Y/N
Telephone:	Telephone:
Fax Number:	Fax Number:

Hospitalization:

Have you been hospitalized recently or since your last visit here at CVAM? Y / N

If yes, please list the name of Facility: _____

After completion of this form please provide to Front Office Clerk.