

Cardiology of Virginia, Inc.

Conditions of Registration and Financial Policy

Patient Name: _____ Date of Birth: _____

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

Basic Financial Policy: Payment is due and payable at the time service is provided unless other arrangements have been made.

For Patients with Insurance: All co-payments and deductibles are due at the time of service. If you do not have your co-pay, you will have 7 calendar days to make payment or you will be charged an additional \$15. We may bill insurance carriers for you if we have a current contract with your carrier. Given that the agreement with you insurance carrier is private; we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, our fees are due and payable in full from you.

For Patients with Medicare: All co-payments and deductibles are due and payable at the time of service. We will bill Medicare for you. We may also bill secondary insurance carriers for you.

Non-Covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.

Returned Checks: In addition to the face value of the check, or each check returned to us by your bank, you will be assessed a "bank returned check fee" equal to the amount charged to us by our bank, plus a \$35 processing fee.

Missed Appointments: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel an appointment. We reserve the right to charge you \$25 for each appointment that was missed or not canceled with 24 hours notice. For missed nuclear testing appointments, we will charge an additional \$100 to help cover the cost of the radioisotope used in the procedure.

Unpaid Balances: Charges reflected on billing statements are agreed to be correct and reasonable unless disputed in writing within thirty (30) days of the billing date. All unpaid balances will accrue interest at the rate of 1.5% per month or 18% per annum. If your unpaid balance is turned over to an attorney or collection agency for collection, you agree to pay all costs associated with collection, to include attorney fees equal to 33% of the unpaid balance.

MEDICARE PATIENTS: SIGNATURE ON FILE

I request and authorize payments of Medicare benefits be made to Cardiology of Virginia, Inc. 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 elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of all information to the insurer or agency that is 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.

Patient Initials _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Cardiology of Virginia, Inc. This assignment will remain in effect until revoked by me in writing. I understand that I remain financially responsible for all charges whether or not the charges are paid by said insurance to the extent permitted by law. I hereby authorize said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

Patient Initials _____

I have read, understood, and agree to be bound by the terms of this financial policy.

Signature: _____ Date _____