Paris Cardiology Center

Khalid Shafiq, MD, FACC, FSCAI

Diagnostic & Interventional Cardiology
Diplomate American Board of Internal Medicine,
Cardiovascular Disease and Interventional Cardiology

FINANCIAL POLICY STATEMENT

In an effort to provide the best medical services, we have established the following policies.
Your signature below signifies your willingness and understanding to comply with our policies.

POLICY STATEMENT: **PAYMENT POLICY** _____ Initial

- You will be required to provide proof of insurance at every visit. In compliance with new Federal law, we will ask you for photo identification and may take your picture at your first office visit.
- It is impossible for our office staff to be aware of each insurance plan's specific requirements or to guarantee coverage by any individual plan. We will do our best to assist you, however it is ultimately your responsibility to verify that we are a member of your PPO or HMO network.
- Your plan may have limitations on the frequency of services performed or where the services may be performed. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements.
- As with any provider's office, any charges you incur at Hands On Medicine, which are not paid or adjusted by your insurance carrier, will be your sole responsibility. As a courtesy, we are glad to bill your insurance carrier on your behalf.
- If you do not have insurance or lose your insurance, we will be happy to provide care for you. However, you will be required to **pay in full** at the time of your office visit. We provide reduced rates for cash paying patients.
- If your deductible hasn't been met for the year, we may require you to pay in full at the time of your office visit. We will then bill your insurance and refund you any claims that are reimbursed.
- We accept cash and credit or debit card payments. Except for balances sent in the mail. There is a $40.00 bounced check fee in addition to fees charged by your financial institution.
- Payment is due within 30 days of receiving your bill. If your balance is not paid in full within 90 days your account will be sent to collections.

- Hands On Medicine is happy to continue providing care while you pay off this balance provided all office visits and other charges acquired from this day forward are paid in full at the time of service.

POLICY STATEMENT: **PRESCRIPTION REFILL POLICY** _____ Initial

- Please allow **3-5 business days for all prescription refills**. Ask your pharmacy to fax a refill request to the clinic at (903) 739-2700 or Toll Free at (866) 871-2700 to speed up the process. If you use a mail order pharmacy, please allow 2 to 3 weeks.

POLICY STATEMENT: **RECORDS** _____ Initial

- We are happy to provide you a copy of your medical records gratis. However additional copies will require a charge in accordance with OAR 847-012-000.

POLICY STATEMENT: **CHANGES IN DEMOGRAPHIC/INSURANCE INFORMATION** _____ Initial

It is **your responsibility** to advise the clinic of any change in **insurance coverage**, or **changes in name, address, or telephone number.**

Signature: _____ Date: _____

POLICY STATEMENT: **24-HOUR CANCELLATION/NO-SHOW POLICY** _____ Initial

- Our clinic policy requires a **24-hour cancellation notice** for all appointments. Your appointment time is reserved for you. If you do not show or give the clinic less than 24-hour notice, you will receive a letter and a bill in the mail. If you repeatedly neglect this policy, you will be dismissed as a patient.
- If you cannot make it to your scheduled appointment, please call to reschedule (you may leave a message after hours). This allows us to give your appointment time to another patient who needs to be seen on that day, and helps us find time for you when you need to be seen on short notice.
- On Clinic Test / Cath / Surgical procedures $50 on missed appointment visits.
- **This charge will not be paid by your insurance company**.

Policy Statement: Referral Policy _____ Initial

In benefits plans that require the issuance of referrals for specialist care, the primary care physician is responsible for coordinating his/her patients' health care. If it is necessary for the patient to see a specialist, other than for direct-access services or emergency care, the primary care physician must request a referral to the patient's visit to the specialist. The referral must be for covered benefits under the plan.

I have read and understand the Policy for Paris Cardiology Center.

Signature: _____ Date: _____

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PATIENT FINANCIAL RESPONSIBILITY STATEMENT

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through

* If you have out-of-network benefits, we will be happy to give you a receipt so you may file.
* You must pay any copayment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
* The remainder of your bill will be sent to your health plan for direct payment to our office.
* If your insurance carrier has not paid our claim within 120 days, we may expect payment from you.
* If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
* You will remain responsible for any services that are not covered by your insurance plan.
* 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 30 days.
* If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, a $25 service charge will be added to your balance due.
* Your health plan may refuse payment of a claim for some of the following reasons:
  1) This is pre-existing illness that is not covered by your plan
  2) You have not met your full calendar deductible
  3) The type of medical services required is not covered by your plan
  4) The health plan was not in effect at the time of service
  5) You have other insurance which must be filed first

Although, benefits maybe verified at the time of service, any payment collected may not reflect the full patient responsibility. Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company, which will result in you paying more for your services.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our priority is to provide you with the best possible care. We are pleased to welcome you to our practice.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier.

_____ _____

Patient Signature Date

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Please read and sign:

FOR EVERY OFFICE VISIT:

CO-PAYS Are Due In Full.
CO-INSURANCE AMOUNTS (Usually 20%) Are Due In Full.
MEDICARE ONLY PATIENTS Owe Their 20% Of Medicare's Allowed Amount.
MEDICARE W-SUPPLEMENT Insurance Will Be filed w-Any Balance Billed to Pat,ent.
INSURANCE BENEFITS UNKNOWN: 20% Of Charges Are Due In Full.
NO INSURANCE: Total Visit Amount Is Due In Full.

FOR EVERY OFFICE PROCEDURE AND SURGERY:
CO-INSURANCE AMOUNTS (Usually 20%) Are Due In Full.
MEDICARE ONLY PATIENTS Owe Their 20% Of Medicare's Allowed Amount,.
MEDICARE W-SUPPLEMENT Insurance Will Be Filed w-Any Balance Billed to Patient.
INSURANCE BENEFITS UNKNOWN: 20% Of Charges Are Due In Full.

NO INSURANCE: Total Visit Amount Is Due In Full Unless Other Prior Arrangements Have Been Made.
Please Ask Receptionist.

PROCEDURE SCHEDULED:
PROCEDURE DEPOSIT Is Due 1 Week Prior To Procedure Date.
PROCEDURE DEPOSIT AMOUNT Is Based On The Estimated Patient Balance Owed.

If you want to set up "Payment Plan" with our office, you should do so on your visit to the doctor. Any amount due after your insurance has paid will be billed to you. After fifteen days when you receive your bill, and you have not paid, you will be sent a collection letter from our office. Please make a payment within the following week or contact our office to settle your account thru a payment plan. You must pay off account in three installments or you can settle your account in one installment and receive a discount.
If we do not hear from you, your account will be turned over to an outside "Collection agency".

ANY BALANCES REMAINING after the above amounts are collected will be billed to the patient.
I have read the above policy and agree to payment as stated.

_____ _____

Patient or Responsible Party Date

Your signature below indicates you understand that if you receive covered services and/or diagnostic test from Paris Cardiology Center and have an HMO insurance or other insurance that requires the “contracted” Primary Care Physician to provide a referral/ pre-authorization for services and has not presented Paris Cardiology Center with such documentation, you may be financially responsible for such services.

If you have received prior approval from your primary care physician, you should contact his or her office and request that he/she forward a copy of the referral/authorization to this office immediately. They may fax this information to 903-491-9031. Services otherwise, may be subject to rescheduling.

_____ _____

Patient or Responsible Party Date