

## **Georgia Heart and Vascular Center, P.C.**

### **Financial Policy and Billing**

Our goal is to provide you with very good care and service. Attached is a copy of our financial policy. It is very important you review this policy. If you have any questions before your appointment please call (478) 745-5476 to speak with a financial counselor.

We are transitioning to a new electronic medical record computer system requiring a change in our registration process. What does this specifically mean for our patients and billing?

Each visit, during the registration process, your statement or account balance will be reviewed prior to services rendered. The final part of your registration process will be to review your financial obligations to ensure the accuracy of your bill. We will ask you to pay any co-payments, deductibles, and outstanding balances at this time.

In addition, your registration process will include updating your demographic, insurance and health information. This process is important as we implement an electronic medical record and become a “paperless” office. This process will improve the quality of patient information we use to care for you.

Our policy states that any account balance remaining **after** insurance payments must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time. All co-pays, deductibles, and previous account balances must be paid before additional services will be rendered.

We hope this brief overview is helpful. We are excited about the opportunity to provide you with very good care and service. If you have any questions or concerns, please contact the office. Thank you.

# Georgia Heart and Vascular Center, P.C.

## FINANCIAL POLICY

We are dedicated to providing you with very good care and service, and we regard your understanding of our financial policies as an essential element of your care.

### **Patient Responsibilities**

We will bill your insurance company. Please have all current insurance cards available so that we may copy the front and back of the card for accurate information. It is your responsibility to inform Georgia Heart and Vascular Center (GHVC) of any insurance changes. If accurate insurance information is not provided for timely submission of a claim, you will be held responsible for the full amount of the charges.

You will be asked to sign an authorization for your insurance carrier to send payments **directly** to GHVC. Any payments sent directly to the patient should be forwarded to GHVC with the Explanation of Benefits to prevent your account being subject to collection procedure and legal action. Authorization must be signed at the initial visit, upon any change in insurance and annually thereafter.

Resources are available through your insurance company to understand your insurance coverage. These services will help you to verify that GHVC is a participating provider with your insurance company. All referrals to GHVC are to be obtained **prior** to your appointment. This will prevent your appointment from needing to be rescheduled.

## **Payment Policy**

### Insured

All co-pays and deductibles must be paid before services are rendered. If unable to pay your co-pay at the time of service, your appointment may be rescheduled. Non-contracted insurance claims will be submitted to the insurance company as a courtesy to you however the charges remain your responsibility. If no response is received from your insurance within 60 days, payment must be made by you.

### Non-Insured

GHVC requires full payment at the time of service unless prior arrangements have been made with our Billing Office. These arrangements may consist of three equal payments (first payment required at the time of service).

### Balances Due

Patient balances remaining **after** insurance payments must be paid in full within 30 days of the first statement, unless specific arrangements are made ahead of time.

Hospitalizations

It is your responsibility to notify your insurance company and primary care physician's office in the event of an unscheduled hospitalization. It is also your responsibility, not the hospital's to provide GHVC with your insurance information.

**Print Name**

**Date of Birth**

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**Signature Today's Date**

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# Georgia Heart and Vascular Center

## AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION

I give Georgia Heart and Vascular Center Cardiology , P.C., and staff authority to release medical information regarding my care, to the individuals listed below, if unable to contact me. This authority will be in effect for one (1) year unless otherwise updated below.

### NAME RELATIONSHIP TO PATIENT

_____	_____
_____	_____
_____	_____

Emergency Contact Name

\_\_\_\_\_

Emergency Contact Phone Number

### Initial

\_\_\_\_\_ No, I only want my medical information released to myself

\_\_\_\_\_ Yes, I give my permission to leave messages regarding my test results, appointments, etc., at the following phone numbers \_\_\_\_\_

\_\_\_\_\_ No, do not leave messages regarding my test results, appointments, etc.

Patient Name \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Witness

\_\_\_\_\_

Updates

### FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgment of receipt of this **AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION** but could not because:

\_\_\_\_\_ Individual refused to sign

\_\_\_\_\_ Communication barrier

\_\_\_\_\_ Care provided was emergent

\_\_\_\_\_ Other

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Georgia Heart and Vascular Center

**PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE**

I have received a copy of Georgia Heart and Vascular Center Cardiology Consultant's, P.C., Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

\_\_\_\_\_  
Printed Patient Name Date of Birth

\_\_\_\_\_  
Name if Signed by Individual Other Than Patient Relationship to Patient

\_\_\_\_\_  
Signature Date

## NOTICE OF PRIVACY PRACTICES

Georgia Heart and Vascular Center, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Georgia Heart and Vascular Center, P.C. (the "Practice") is dedicated to maintaining the privacy of your personal health information. Each time a patient visits the office a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practices will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

- 1. TREATMENT:** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
- 2. PAYMENT:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
- 3. HEALTH CARE OPERATIONS:** We may use and disclose health information to operate our business. For example your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.
- 4. APPOINTMENT REMINDERS:** We may use and disclose your information to remind you of appointments. We may also mail you a reminder postcard for follow-up visits.
- 5. TREATMENT OPTIONS:** We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
- 6. BUSINESS ASSOCIATES:** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases
- For workers' compensation or similar programs as required by law
- To authorities when we suspect abuse, neglect, or domestic violence
- To health oversight agencies
- For certain judicial and administrative proceedings pursuant to an administrative order

For law enforcement purposes  
To a medical examiner, coroner, or funeral director  
For the facilitation of organ, eye, or tissue donation if you are an organ donor  
For research purposes under strictly limited circumstances  
To avert a serious threat to your health and safety or that of others  
For governmental purposes such as military service or for national security  
In the event of an emergency or for disaster relief  
In any other instance required by law

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing. All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it. YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED. DONNA DEPONTE, PRIVACY OFFICER, 6750 E. BAYWOOD # 301 MESA, AZ 85206

- 1. RESTRICTIONS ON USE AND DISCLOSURE:** You have the right to request restrictions on how we use and disclose your health information. This includes request to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
- 2. CONFIDENTIAL COMMUNICATIONS:** You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
- 3. ACCESS:** You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
- 4. RECORD AMENDMENT:** You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
- 5. ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures practice had made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
- 6. COPY OF NOTICE:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this notice, please contact Practice's Privacy Officer at (480) 835-6100. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.