

Office and Financial Policy

This is an agreement between Greater Cincinnati Cardiovascular Consultants, Inc. (GCCC), as creditor, and the Patient named on this form.

In this agreement the words "you," "your" and "yours" mean Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The word "we," "us" and "our" refer to GCCC.

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

Insurance Cards:

It is your responsibility to provide all current insurance card(s) at the time of each visit. If you do not have your insurance card(s) at the time of treatment you will be given five (5) business days to provide the correct information to our office. Your claim may not be filed to the insurance company until this information is received and you could be held financially responsible for any and all charges incurred.

Referrals:

If your insurance requires that you have a referral, it is your responsibility to obtain one prior to your appointment or you may be held financially responsible for your visit.

Monthly Statements:

If you have a balance of \$4.00 or more on your account, we will send you a monthly statement. It will show each outstanding date of service with any items pending insurance marked with an asterisk. It will also give you a total "due from patient". This is expected upon receipt of statement. If you have a balance under \$4.00 it will be collected on your next visit to the office.

Payment options if you have no insurance:

- A. You will pay the office visit in full by cash, check or credit card on the day treatment is rendered.
- B. On treatment involving Echo, Stress Tests, Nuclear Stress Tests or any other diagnostic testing, you will make a minimum payment of \$100.00 and sign a payment agreement for the remaining balance.

Payment options if you have a participating insurance:

(Please be prepared to show your insurance card at each visit or you may be financially responsible for all charges)

- A. You will pay your deductible or co-pay by cash, check or credit card on the day treatment is rendered.
- B. We will file your claim with the insurance company.

Payment options if you have a non-participating insurance:

(Please be prepared to show your insurance card at each visit or you may be financially responsible for all charges)

- A. You will pay the office visit in full by cash, check or credit card on the day treatment is rendered.
- B. On treatment involving Echo, Stress Tests, Nuclear Stress Tests or any other diagnostic testing, you will make a minimum payment of \$100.00 and sign a payment agreement for the remaining balance.
- C. As a courtesy, we will file your claim with the insurance company.

Past Due Account:

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, you may be dismissed from GCCC.

Returned Checks:

Any check returned to us from the bank will automatically receive a \$20.00 charge. Additional charges may occur. Returned check and related charges must be paid by cash or Money Order. Failure to pay returned check and any fees may result in dismissal from GCCC.

Transferring of Records:

We require a request in writing if you want your records sent to another physician. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another physician to us, you authorize us to receive all relevant information including your payment history.

Worker's Compensation:

If you have a work related injury, we need to have a Bureau of Workers Compensation or MCO (Managed Care Organization) information at the time of your first visit. If your claim is denied, you will be responsible for payment in full.

No Show:

Effective May 1, 2010, we are implementing the following policy for anyone who no shows for a scheduled appointment without notifying the practice at least 24 hours in advance of the appointment. The purpose of this policy is to protect the practice from loss of appointment times for patients with medical needs. This is a practice policy and is not related to any insurance rules or regulations. GCCC will not charge patients for the first No Show appointment scheduled with a doctor or nurse. All other No Show appointments will be billed according to the terms as described below.

- For all No Show appointments for an office visit with a doctor or nurse, the patient will be billed the amount of the lowest level office visit for either a new or established patient, based on the GCCC fee schedule in effect on the date of the scheduled appointment. Patients who no show for protime appointments will be charged \$15.00.
- For all No Show appointments for a nuclear stress test, a vascular test, an echocardiogram, or a stress echocardiogram, the patient will be billed \$100.
- Patients who no show for their appointment due to admission to a health care facility for illness or injury will not be charged for a No Show.
- Special situations, such as inclement weather, will be evaluated according to individual circumstances.
- Payment for a No Show appointment is the responsibility of the patient and is due upon receipt of the charge.
- GCCC reserves the right to postpone scheduling of future appointments until fees for No Show appointment(s) have been paid.
- Patients who no show for three or more scheduled appointments will be subject to termination from the practice.
- Notice of this policy will be posted in patient traffic areas, on GCCC's website (www.gcccheart.com), and will be included in appointment scheduling materials.

Administration Fees:

Effective May 1, 2010, we are implementing the following policy for Administrative Services provided by our practice. This policy is for non-covered services that are not billed to any insurance company. These Administrative Services do not include any "medically necessary treatments" or other "covered" expenses. The below Administrative Services Fee Schedule is subject to the terms and conditions of the health benefit plan you are a member of and for which our practice is a contract provider.

- Administrative Work Associated with Consultations with Patients/Families without an Office Appointment (\$35.00)
- Department of Transit Form (\$40.00)
- Disability Insurance Form (\$45.00)
- Extended Care Facility Form (\$50.00)
- Family Medical Leave Act Form (\$45.00)
- Handicap Parking Placard (\$25.00)
- Health Club, Fitness Center Medical Clearance Form (\$35.00)
- Home Medical Equipment/Home Care Set-Up (\$20.00)
- Jury Duty Excuse (\$25.00)
- Medical Records (Allowable charge per page based on Ohio Law)
- Social Services Set-Up (\$25.00)
- Work Excuse (\$25.00)
- Worker's Comp Medical Info Request Form (\$45.00)

Account #: _____

Acknowledgment

I hereby acknowledge that I have received a copy of the
Greater Cincinnati Cardiovascular Consultants
Office and Financial Policy including:

- Insurance Card(s)**
- Referrals**
- Monthly Statements**
- Payment Options if you have no insurance**
- Payment options if you have a participating insurance**
- Payment options if you have a non-participating insurance**
- Past Due Accounts**
- Returned Checks**
- Transferring of Records**
- Workers Compensation**
- Missed / No Show Appointments**
- Administration Fees**

By executing this agreement, I agree to pay for all services received in accordance with these policies.

Effective Date:

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in effect.

Patients Name: (Please Print) _____ D.O.B. _____

Responsible party: _____

(If not the parent)

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

Co-Signature: If this or another financial policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.