Oracle Heart & Vascular Inc.

Patient Financial Policy

The following information outlines Oracle Heart & Vascular's Patient Financial Policy to include the PATIENT FINANCIAL AGREEMENT and ASSIGNMENT OF BENEFITS which all outline your financial responsibilities and is an essential element of your care and treatment.

PATIENT FINANCIAL AGREEMENT

As a new or existing patient of Oracle Heart & Vascular, we may request your current identification and a copy of your insurance card or benefit information at the time of visit and possibly upon every appointment.

All information provided to Oracle Heart & Vascular must be accurate and complete, as the contrary may result in a denial of your claim or a delay in payment and could result in your full financial responsibility.

If medical services are related to a work injury or auto accident, please provide all applicable group hospitalization; Health Maintenance Organization (HMO); Workers' Compensation; insurance carrier's name, address or other contact information at the time of visit. All other health care benefits ("Insurance Plan(s)") to which you may be entitled will also be required. If this, or other related information is not provided prior to or at the time of your appointment, you may incur all charges associated with your appointment.

If your insurance policy requires prior verification, referral(s) for services, or any other insurance policy coordination, it is your responsibility and must be provided prior to the time of your visit.

Verification may include coverage for services rendered within or outside of Oracle Heart & Vascular to include facilities/services such as, but not limited to: radiology, laboratory, physical therapy, hospitals, rehabilitation, etc.

Required referrals by your policy must be provided **prior to your visit** or could result in your appointment being rescheduled or an estimate of all charges for your office visit, may be required in advance of services.

If you have a high deductible policy or do not currently have insurance benefits, financial responsibility to pay an estimate of charges for your appointment is due in advance of services.

In the case of out of network/plan services, there may be reduced benefits and may require the payment of larger co-payment(s), co-insurance(s), or other charge(s).

Payment or arrangement for payment of all service(s), copay(s), deductible(s), and remaining balances are due at the time of service or upon receipt for payment. If you are unable to provide payment, your appointment may be rescheduled. We accept cash, check or credit card. All returned checks are subject to a **$25.00 fee**.

Appointment cancelation or rescheduling of appointments must be made 24 hours in advance. All missed appointments are subject to a **$25.00 charge**.

Appointment cancelation or rescheduling for diagnostic ultrasound test and nuclear stress tests must be made 24 hours in advance. All missed diagnostic ultrasound are subject to a **$100.00 charge**. All missed nuclear stress test appointments are subject to a **$280.00 charge**.

Failure to pay or delinquency on any balance remaining on your account may result in Oracle Heart & Vascular, Inc pursuing an outside collection agency. Costs associated with such collection efforts will become your responsibility and may include interest, rebilling fees, court costs, attorney fees, collection agency costs, etc.

All services provided by Oracle Heart & Vascular, Inc are considered medically necessary, if you fail to have a procedure performed or do not comply with your provider's medical advice, this may result in a void of your coverage by your insurance company. Should this occur, you may be required to pay outstanding balances on your account, after insurance has been processed.

Some insurance policies may or may not agree to the usual, customary, or reasonable charges for your local area and may not cover all services or might deny payment for services that have been approved in advance. It will remain your responsibility to pay resulting balances after insurance has been processed.

I, _____ have read, understand and agree to be fully responsible for the information contained within Oracle Heart & Vascular's PATIENT FINANCIAL AGREEMENT as stated here. I hereby assign payment(s), from my Insurance Plan(s) to Oracle Heart & Vascular Inc. (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to myself.

_____ _____

Patient Signature Date

ASSIGNMENT OF BENEFITS

I, _____ hereby authorize direct payment of medical benefits to Oracle Heart & Vascular, Inc. for payment toward my claim and the release of benefits or medical information necessary to pay any secondary insurance payer. This DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS authorization will remain in effect until cancelled by myself in writing. A copy of this authorization is as valid as the original document.

The direct payment hereby assigned and authorized includes any Insurance Plan benefit(s) to which I am otherwise entitled, including any major medical benefits otherwise payable to myself under the terms of my policy but is not to exceed the balance due to Oracle Heart & Vascular Inc. (or its affiliate), the independent contractor physicians and/or professional corporations for services I received during the applicable periods of medical care.

I understand that if my Insurance Plan(s) does not consider the services rendered during this visit and/or a covered service and/or they have not authorized this service that they will not pay for the services rendered. I agree to be fully responsible for payment and any remaining balances to Oracle Heart & Vascular Inc. for any services rendered if determined by my Insurance Plan(s) to be a non-covered service.

I understand that in the case of out of network/plan services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance, or other charge in the event my insurance plan(s) does not reimburse services provided.

I authorize the release of medical information necessary in order to obtain payment.

I authorize the release of medical information to the Health Care Financing Administration and its agents for information needed to determine my benefits.

I authorize Oracle Heart & Vascular, Inc to deposit checks received on my account when made out in my name.

I authorize Medicare benefit payment(s) to be made on my behalf to Oracle Heart & Vascular Inc. and authorize any holder of medial information to be released to the Centers for Medicare & Medicaid Services and its agents if needed to determine these benefits or the benefits payable for the related services.

In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignments.

If I am a Medicare recipient, Oracle Heart & Vascular will bill Medicare as well as my secondary insurance on my behalf.

I certify the information provided in this application for payment is correct, current, and that I am the policy holder or beneficiary of the insurance plan(s) listed on the Patient Demographics form I completed and signed.

I, _____ have read, understand, and agree to be fully responsible for the information contained within Oracle Heart & Vascular's ASSIGNMENT OF BENEFITS as stated here.

_____ _____

Patient Signature Date

_____

Patient Medicare Number

PATIENT AND PRACTICE RESPONSIBILITY SNAPSHOT		
If you have…	**Patient responsibility…**	**Oracle Heart & Vascular responsibility…**
Commercial Insurance	All applicable copays are requested at the time of service	File the patient's insurance claim(s)
HMO & PPO plans with which we have a contract	All applicable copays are requested at the time of service	File the patient's insurance claim(s)
HMO with which we are not contracted	Payment in full for office visits and other charges at the time of service	Provide necessary information to complete and file claim(s) directly with insurance company
Point of Service Plan or Out of Network PPO	All applicable copays are requested at the time of service Payment for all out of network benefit(s), and other charges are due at the time of service	Out of network benefit(s) or point of service plan(s), will be filed as an insurance claim on the patient's behalf
Medicare	If you have Medicare, no payment is required at the time of service	File the patient's claim(s), as well as any claims to secondary insurance plans The patient's responsibility portion will be billed directly to the patient
Medicare HMO	All applicable copays are requested at the time of service	File the patient's claim(s), as well as any claims to secondary insurance plans
Worker's Compensation	If other arrangements have been made and verified in advance with patient insurance carrier(s), then no payment is necessary at the time of service If eligibility is denied, payment in full will be required at the time of service	Gather basic accident details such as date of accident, claim number, primary care physician, employer information, and referral procedures
Worker's Compensation (Out of State)	Payment in full is requested at the time of service File claims with insurance carrier	Provide the patient with a receipt for filing claims with insurance carrier
No Insurance	Payment in full is due at the time of service (please speak with our staff if you need assistance)	Provide financial assistance and options for the patient