C ◈ P ◈ N ◈ A
Cardiovascular Physicians of North Atlanta, PC

NORTHSIDE HOSPITAL

Financial Policy and HIPAA Acknowledgment

This is an agreement between Cardiovascular Physicians of North Atlanta, PC, as creditor, and the Patient/Debtor named on this form.

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

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

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

If you would like for us to discuss your account and the patient information related to the account with other persons or entities, a separate form will be given for you to provide a list of people who are authorized to discuss health and account information with us.

Payment options if you have no insurance:
1. You can choose to pay by cash, check, or credit card on the day that treatment is rendered.
2. We offer special financing through Care Credit. If you pay them within 12 months, there will be no interest charge

Payment options if you have insurance:
1. You are responsible for meeting your yearly deductible and any out-of-pocket portions at the time services are rendered.

Payments: 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 by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. ***If you have a co-pay or deductible, you must pay that at the time of service***. It is the insurance company that makes the final determination of your eligibility. 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. It is your responsibility to be familiar with your insurance plan and its requirements.

Non-contracted Insurance: 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.

Required Payments: Any co-payments required by an insurance company must be paid at the tine of service.

Returned Checks: There is a fee (currently $25) for any checks returned by the bank. We may modify this from time to time.

Missed Appointment Fee: Patients who do not arrive on time for an appointment, or cancel with less than a 24-hours notice will be charged a fee. The fee is as follows: **$25** fee for any regular office visit, **$50** fee for any diagnostic testing with the exception of the stress thallium test which will be **$150**. This fee must be paid before a new appointment is scheduled.

Past Due Accounts: 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 agree to pay all of the collection costs which are incurred which is **35%** of outstanding account balance. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees and expenses, which we incur, plus all court costs. IN CASE OF SUIT, YOU AGREE THE VENUE SHALL BE IN *FULTON COUNTY*, GEORGIA AND SUBMIT TO THE JURISDICTION OF THE COURTS IN FULTON COUNTY, GEORGIA. As stated in the patient's Notice of Privacy Rights, we may use or disclose your protected health information for payment purposes.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record. We may use or disclose your patient information for payment purposes.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy and state law. You will not be charged a retrieval fee. If you are requesting a copy or for your records to be transferred from another doctor or organization to us, you will be provided an "Authorization to Release Information" form to sign.

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

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 full force and effect.

I have read and understand the above. I have been given opportunity to receive a copy of this document upon request.

Patient's Name:_______________________________________

Responsible Party:_____________________________________
(If not the patient)

Signature:___________________________ Date:______________

Co-Signature:______________________ Date:______________

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LIFETIME ASSIGNMENT FOR MEDICARE PATIENTS

I request payments of authorized Medicare benefits be made either to me or on my behalf to CPNA, PC for any services furnished by their physicians. I authorize any holder of medical information about me to release to the Healthcare Financing Administrator and its agents any information needed to determine these benefits or benefits related to payable services.

Beneficiary's Signature:___________________ Medicare Number:_______________ Date:_________

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PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the Notice of Privacy Practices at Cardiovascular Physicians of North Atlanta, P.C., on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Cardiovascular Physicians of North Atlanta, P.C.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

Amy Pachmayer, Business Office Manager- (770)242-2021

Signature of Patient **Printed Name** **Date**

THIS SPACE TO BE USED BY PRACTICE ONLY:
Date acknowledgment denied by patient:
Reason Denied by patient:
Name of person reviewing denial: