Clearwater Cardiovascular Consultants
Financial Policy

Thank you for choosing Clearwater Cardiovascular Consultants for your cardiovascular care. We would like to welcome you to our practice. We believe that a good physician/patient relationship is based on clear communication. The following is a statement about our financial policy, which we require that you read and agree to prior to your visit.

Appointments

If you are unable to keep your appointment, please notify us in advance so that we may offer that time to another patient. Failure to keep appointments and/or late cancellations (less than 24 hours) may result in dismissal from Clearwater Cardiovascular Consultants.

Insurance

As a courtesy to our patients, Clearwater Cardiovascular Consultants will submit your claims to the insurance carriers you have provided. Once the insurance claims have resolved, any remaining balance will become the patient's responsibility. Although we may be able to estimate the payment from your insurance company, it will be your insurance company that determines the final payment based on your eligibility and benefits. **Your insurance is a contract between you and your insurance company; therefore, your balance is your responsibility.** Certain services provided may be considered non-covered services and not paid for by your insurance company. You are personally responsible for those services.

Please bring your insurance cards with you to your visits so that we can ensure that the information we have on file is correct and up to date. In the event of any changes to coverage, please contact our billing office at **727-445-1990** with the current information. Out-of-date information may result in patient responsibility for the visit.

Copays/Coinsurance/Deductibles

Patients are responsible for co-payments, co-insurance, and deductibles at the time of service.

Self-Pay

Should you not have insurance coverage, you will be responsible for paying at the time of your visit.

Payments

Clearwater Cardiovascular Consultants accepts cash, personal checks, and most major credit cards. Patients can also pay on our secure portal at www.cccheart.com under the **Pay My Bill** tab, or by calling the Patient Billing Dept. at **727-445-1990**. We **do not** accept third-party or post-dated checks. We charge a $35.00 NSF fee for any returned checks.

Fees

There is a $25 charge for the completion of paperwork, such as FMLA or disability.

Collection Agency

Clearwater Cardiovascular Consultants uses an outside collection agency for financial recovery when necessary. An administration fee of 35% will be assessed to your account to recover any financial losses.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. Questions about financial arrangements should be directed to the **Patient Accounting Department at: (727) 445-1990**. We are here to help you.

I have read and understood the above Financial Policy and agree to meet all financial obligations.

_____ _____/_____/_____

Patient Name (Please Print) Patient Date of Birth

_____ _____

Patient Signature Date

Clearwater Cardiovascular Consultants

Insurance Assignments, Release of Information, and Financial Policy

Consent to Disclosure of Health Information

To facilitate the treatment services provided to me pursuant to this consent, for payment purposes, and to coordinate my care, I hereby authorize and request that copies of my medical/health records be provided to Clearwater Cardiovascular Consultants and authorize Clearwater Cardiovascular Consultants to disclose my health information to other outside health care providers providing treatment services to me. I understand that Clearwater Cardiovascular Consultants, its business associates, any provider and/or my insurance company may obtain, use and/or disclose my health information for the purposes of treatment, payment, and normal health care operations. This includes without limitation, all medical records, complete plans of treatment, progress summaries, treatment notes, including without limitation mental health information and diagnosis, substance use, and any other appropriately related documents or information reasonably requested to facilitate providing treatment to me.

Insurance Authorization, Release and Assignment of Benefits

I hereby authorize Clearwater Cardiovascular Consultants to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the Clearwater Cardiovascular Consultants all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

Financial Responsibility

I have requested medical services from Clearwater Cardiovascular Consultants and/or its legal entities on behalf of myself and/or my dependents, and I understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medigap, private insurance and any other health/medical plan to issue payment directly to Clearwater Cardiovascular Consultants, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage.

I acknowledge I have received a copy of the Clearwater Cardiovascular Consultants Notice of Privacy Policies. I have read, understand, and agree to the terms noted in the Notice of Privacy Policies.

I have read and understand all the information, notices and consents as listed and agree to comply with its terms. I further state that all information provided by me to Clearwater Cardiovascular Consultants is accurate and complete.

_____ _____/_____/_____

Patient Name (Please Print) Patient Date of Birth

_____ _____

Patient Signature Date

Clearwater Cardiovascular Consultants

Standing Authorization to Discuss Health Information

In many cases, HIPAA allows providers to share protected health information ("PHI") with family members and friends that patients choose to involve in their health care or payment for their health care, so long as the patient does not object after having the opportunity to do so. The disclosure of certain sensitive information also requires a patient's prior written consent. Please list below the name(s) of the individual(s) you authorize Clearwater Cardiovascular Consultants to discuss your health care treatment and billing information with. Your PHI will be disclosed to the individual(s) listed below unless/until you notify us otherwise in writing.

1. _____ Name _____ Relation

2. _____ Name _____ Relation

3. **DO NOT SHARE MY PHI WITH ANYONE** _____ Signature of Patient

I understand that I may cancel this authorization at any time in writing by notifying Clearwater Cardiovascular Consultants. However, if I cancel this authorization, I also understand that the cancelation will not affect any action Clearwater Cardiovascular Consultants took in reliance on this authorization before receipt of written notice of cancellation.

_____ Patient Name (Please Print)

_____ / _____ / _____ Patient Date of Birth

_____ Patient Signature

_____ Date