MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

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273 Winton M Blount Loop P. O. Box 241587 Montgomery, Alabama 36124-2398
Phone (334) 280-1500 Fax (334) 280-1600
www.mcva.com

Please take the time to review the enclosed

Financial Policy

Patient Authorization for Use or Disclosure of Protected Health Information.

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Please complete the following and bring it to your appointment.

HIPAA Permission for Release of Information

You will need to bring the following items with you to your appointment:

1. Driver's License and Insurance cards to use to register with our sign-in kiosk.
2. All of your medications in the bottles.
3. If you are scheduled to see our doctor please have your primary physician fax any recent EKG, X-rays, or other records helpful to your care to our fax # 334-280-1600.
4. All copays are due at the time of service.

Thank you for choosing Montgomery Cardiovascular Associates and we look forward to seeing you on your visit.

MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

MONTGOMERY, ALABAMA 36117

Financial Policy

Thank you for choosing Montgomery Cardiovascular Associates, P.C. (MCA) as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays
Patients are expected to present their insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Preauthorizations:
If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring **$200** at the initial appointment and may be billed for any additional balance. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Missed Appointments
MCA requires 24-hour notice of appointment cancellation. Physician appointments missed and are not previously canceled may be charged a fee of $25. Diagnostic appointments missed and are not previously canceled may be charged a fee of $50.

Returned Checks
The charge for a returned check is $30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Record Copies
Patients requesting copies of medical records will be charged:
$5 retrieval fee

$1 per page for pages 1-25
$0.50 per page for pages > 25

A special handling fee of $10 will be charged if records must be delivered within 48 hours of the request.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a single phone call or letter will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.
Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I have read and understand MCA's financial policy

*Signature*_____*Date:*_____

MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

MONTGOMERY, ALABAMA 36117

Patient Authorization for Use or Disclosure of Protected Health Information

With my consent, MCA may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to MCA's Notice of Privacy for a more complete description of such uses and disclosures. These notices are made available to you in each reception area, at each registration desk, and posted on the Montgomery Cardiovascular Associates, PC website at www.mcva.com .

I have the right to review the Notice of Privacy prior to signing this consent. MCA reserves the right to revise its Notice of Privacy at anytime. A revised Notice of Privacy may be obtained by forwarding a written request to: MCA, 273 Winton M Blount Loop, Montgomery, AL 36117.

I understand that this authorization shall be in force and effect until I, the patient, request otherwise at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: MCA, 273 Winton M Blount Loop, Montgomery, AL 36117**.**

I understand that MCA may mail, call, or email to my home or other designated location any items that assist MCA in carrying out treatment, payment, and/or healthcare operations. (ie: appointment reminders, insurance items, information regarding my clinical care, lab results, patient statements, among others). I understand that MCA has the right to use my medical data in a de-identified manner for research purposes. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that if I refuse to sign this authorization I may not be eligible for, or receive treatment that I have requested for the purpose of disclosure to others.

I understand that I have a right to request a restriction on how MCA uses or discloses my Health information. However, MCA is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the MCA has already made disclosures in reliance upon my prior consent.

By signing this form, I am consenting to MCA's use and disclosure of my Health information to carry out **treatment, payment and healthcare operations.**

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

(If signed by Legal Representative, state relationship and authority to do so) Signature of Witness

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HIPAA Permission for Release of Information

Patient Name: _____Date of birth: _____

MCA account #: _____

Due to HIPAA, we cannot leave medical information on your voicemail, send it by email or leave it with a member of your family. It is for that reason that we are having you give us authorization via this form.

A. If you would like to authorize to have information released to someone other than yourself, please complete the following:

Please list names of people authorized to receive your health information:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

B. I authorize Montgomery Cardiovascular Associates and staff to leave medical information pertaining to my care by the following methods and will assume responsibility of notifying Montgomery Cardiovascular Associates whenever this information changes. Please list phone #, fax# or email address and check below all that applies.

Home Answering Machine #_____	[ ] Yes [ ] No [ ] N/A
Work Telephone #_____	[ ] Yes [ ] No [ ] N/A
Cell phone Voicemail _____	[ ] Yes [ ] No [ ] N/A
Work Fax #_____	[ ] Yes [ ] No [ ] N/A
Home Fax #_____	[ ] Yes [ ] No [ ] N/A
Email Address_____	[ ] Yes [ ] No [ ] N/A

[ ] I would prefer not to have messages left.

[ ] I give permission to electronically access prescription medication history from pharmacies that participate in E-Prescribing.

[ ] I do not give permission to electronically access prescription medication history from pharmacies that participate in E-Prescribing.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

(If signed by Legal Representative, state relationship and authority to do so) **Signature of Witness**