Payment Policy and Patient Financial Agreement

Welcome to Arizona Arrhythmia Consultants. Our goal is to provide you quality medical care in a friendly, safe, and caring environment. We are committed to maintaining the highest standards of ethics and integrity. We are committed to ensuring that all affairs are conducted in accordance with all applicable laws, rules, regulations, policies, and procedures. We are committed to the care and improvement of our patients.

We consider you a partner in your own medical care. When you are well informed, when you participate in treatment decisions, and when you communicate openly with your doctor and other health care professionals, you make your care as effective as possible. You have the right to consent to or refuse a treatment as permitted by law throughout your treatment. You have the right to privacy; we will protect your privacy as much as possible as outlined in our privacy notice. You are responsible for providing information about your health, including past illnesses, hospital stays, and use of medicine. You are responsible for asking questions when you do not understand information or instructions. You are responsible for following instructions for your planned course of treatment.
If you believe you can't follow through with your treatment, you are responsible for telling your doctor.

FINANCIAL AGREEMENT
Timely payment for services received allows us to better manage the rising health care costs and continue to maintain the optimum standards of quality care. To ensure timely payment, we look forward to working with you to make the resolution of your account here as pleasant and comfortable as possible.

Arizona Arrhythmia Consultants requires the payment of any portion of our services that are patient responsibility at the time of service. If you are covered by an insurance plan that Arizona Arrhythmia Consultants participates with and the plan requires a co-pay, we will collect the co-pay at the time of service.

Please read and sign this form

1. **Payment methods:** Payments may be made by cash, check, credit card, debit card.

2. **Insurance:** Arizona Arrhythmia participates in most insurance plans, including Medicare. If you are not insured by a plan, but you are either missing an updated insurance card or you cannot provide the policy and/or group# you will be responsible. You will be required to pay for your visit in full until our office is able to confirm your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

3. **Co-payments and deductibles:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. **Non-covered services:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurers. You will be billed for these services.

5. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. **Claims submission:** We will submit your claims and assist you in any way reasonable to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If payment is denied due to a lack of response from you, the balance will immediately become due and payable by you. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

7. **Coverage changes:** If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits.

8. **Workers Compensation:** You will be responsible for your services until your Worker Compensation claim/condition is allowed. If, after 30 days, your claim or condition has not been allowed, your bill will be due and payable in full. You will be

reimbursed if and when Workers Compensation pays for your services. If there is any dispute or denial of your claim, you will be responsible for these changes.

9. **Personal Liability/Self Pay:** Personal liability or self pay patients are responsible for payment at the time of services. We will do our best to ensure that charges incurred during your visit will be will communicated prior to services being rendered.

10. **Un-Insured Patients:** If you are not insured or are not covered by a plan for which we are not providers, payment is expected at the time of services.

11. If patient balances are not paid within 90 days of receiving a statement, your account **may** be turned over to our collection agency.

12. **For New Patients**: If you are for any reason unable to keep your appointment, we do require that you provide us with 48 hours notice to avoid a charge of $300. Also, if you cannot attend the above scheduled appointment; please notify us immediately, as we currently have a waiting list for the physicians.

13. **For Existing Patients:** We require a 48 hour notice for all cancellations or reschedules. Failure to call will result in a $25.00 no show fee.

FEES NOT COVERED BY YOUR INSURANCE PLAN:

- FMLA, disability forms, or waivers, letters other than communication with your primary or cardiology provider will result in $40 pre-payment

Hospital charges and lab bills are between you and the hospital. Arizona Arrhythmia Consultants is not able to assist you with these responsibilities.

Failure to provide complete insurance information may result in patient responsibility for the *ENTIRE* bill.

I hereby authorize my insurance benefits to be paid directly to Arizona Arrhythmia Consultants. I authorize the release of any medical or other information necessary to process insurance claims. Office fees, no-show fees, returned check and credit card fees and finance fees are my responsibility. By signing this agreement, it is understood that I, or as the guardian of a minor, understands and agrees to abide by our Patient Financial Policy and will accept the conditions thereof.

Patient Name (print) ____ **Date of Birth** ______________________________

Signature ____ **Date** ____________________________________

All patients are required to sign and updated Financial Agreement every year.