RIVER CITY
VASCULAR SPECIALISTS

NO SHOW POLICY

IF YOU HAVE A SCHEDULED APPOINTMENT FOR AN ULTRASOUND AND DO NOT NOTIFY OUR OFFICE WITHIN AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT TIME YOU MAY BE SUBJECT TO PAY A NO SHOW FEE OF $40.00 PER ULTRASOUND.

IF YOU HAVE A SCHEDULED APPOINTMENT WITH ONE OF OUR PROVIDERS AND DO NOT NOTIFY OUR OFFICE WITHIN AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT TIME YOU MAY BE SUBJECT TO PAY A $30.00 NO SHOW FEE.

WE KINDLY ASK YOU TO PLEASE NOTIFY OUR OFFICE IN ADVANCE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT TO AVOID BEING CHARGED A FEE.

****YOU WILL NOT BE RESCHEDULED FOR ANY APPOINTMENTS UNTIL THE NO SHOW FEES HAVE BEEN PAID. ****

SIGNATURE: _____

-THANK YOU

PATIENT INFORMATION FORM

PATIENT NAME:

_____

DOB: _____/_____/_____

SOCIAL SECURITY #: _____

SEX: M ___ F___

MARITAL STATUS: _____

RACE: _____ ETHNICITY: _____

PREFERRED PHONE #: _____
ALTERNATE PHONE #: _____

PREFERRED LANGUAGE: _____

MAILING ADDRESS:

_____

_____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME: _____

POLICY OR ID#: _____

GROUP #:_____

POLICY HOLDER NAME: _____

POLICY HOLDER DOB: _____

POLICY HOLDER SSN: _____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME: _____

POLICY OR ID#: _____

GROUP #:_____

POLICY HOLDER NAME: _____

POLICY HOLDER DOB: _____

POLICY HOLDER SSN: _____

I UNDERSTAND THAT PAYMENT OF ALL MEDICAL CARE IS DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID BY MY INSURANCE COMPANY. I UNDERSTAND THAT COPAYS ARE DUE AT THE TIME OF THE OFFICE VISIT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COST INCURRED IN THE COLLECTION OF PATIENTS ACCOUNT IN CASE OF DEFAULT, INCLUDING REASONABLE ATTORNEY FEES AND COURT COSTS.

SIGNATURE: _____DATE: _____

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Our notice of privacy practice provides information about how we may use and disclose protected health information (PHI) about you. The notice contains a patient's rights section describing your rights under law. You have the right to review our notice before signing this acknowledgement. The terms of our notice may change, if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

Please list names of individuals that we may **TALK** to about your treatment. Please note this does not allow these individuals to obtain copies without a complete and valid authorization from the patient.

NAME: _____ PHONE #: _____
NAME: _____ PHONE #: _____
NAME: _____ PHONE #: _____

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of River City Vascular Specialists.

SIGNATURE: _____

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. The following is our financial policy. Our main concern is that you receive the best care and proper treatment for your healthcare needs. Therefore, if you have any questions or concerns about our payment policies, please don't hesitate to ask one of our staff members.

Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. ALL CO-PAYMENTS, UNMET DEDUCTIBLES AND OTHER PATIENT RESPONSIBLE SERVICES MUST BE PAID AT THE TIME OF THE VISIT. If your insurance applies the billed charge to your deductible, and denies the services non-covered, you are responsible for the payment of the service.

IF YOU DO NOT HAVE INSURANCE PRIOR ARRANGEMENTS MUST BE MADE BEFORE THE VISIT. In event your insurance does not pay the claim within a reasonable amount of time (40-60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency. We will send 3 (three) statements and if we don't get a response the account will be reviewed for collection. If this becomes a problem your account will be discussed with the physicians for further action. If your insurance requires a referral or prior authorization, you must present this along with your insurance ID at the time of the visit. If you do not have the referral with you and we can't get it, payment for the visit becomes your responsibility. Returned checks will be subject to a fee of $35 and must be picked up and paid for with cash or money order.

PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Administration or intermediaries or carrier any information needed for this or related Medicare claim. I request that payment assignment benefits be made on my behalf.

FINANCIAL AGREEMENT: The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance; it is understood the obligation to pay the practice may not be deferred for any reason, including pending legal action against other parties to cover medical costs.

CONSENT FOR ROUTINE TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at RCVS. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand my medical care may require the collection of samples, including fluids or tissue from my body. I understand that should any staff personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including hepatitis band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations at RCVS. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS.

SIGNATURE: _____

DATE: _____