

# NEW MEXICO CARDIOVASCULAR ASSOCIATES (NMCVA)

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## FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. 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 carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 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.
3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
4. Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.
5. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** 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 Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.
6. **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's 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 actions against other parties to recover medical costs.
7. **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 NMCVA. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any hospital or emergency medical 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 examination at NMCVA. 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.
8. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT DISCHARGE:** I authorize the facility to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility/facilities identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the

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Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

9. **ADVANCE DIRECTIVE:**  I have executed an Advance Directive  I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

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Signature of patient, legal representative for health care services      Date

If other than patient:

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Relationship of Representative      Reason individual is unable to sign, i.e. minor or legally incompetent