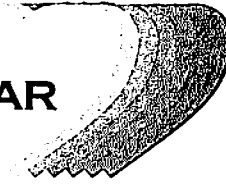


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SAN DIEGO CARDIOVASCULAR ASSOCIATES



Diplomates, American Board of Internal Medicine & Cardiovascular Diseases

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FINANCIAL POLICY

It is the policy of this office to collect payment at the time of your visit for services rendered unless other arrangements have been made. As a courtesy to our patients, we will be happy to bill your insurance if you provide us with the necessary information to do so. You however are responsible for your bill regardless of any insurance coverage you may have.

Medicare Patients: We accept assignment for Medicare patients. This means that we will accept the amount that Medicare **approves** as our full fee. We are required by law to bill Medicare for services rendered and charge according to Medicare's established fee schedule. Please do not bill Medicare yourself. You are still responsible for your deductible and any co-insurance amount, as well as any non-covered services you chose to receive after being notified in advance by our office that Medicare will not pay for these services.

HMO Patients: We do belong to several HMO groups. Please be sure to get a referral from your primary doctor before making an appointment with us. You are responsible for your copayment when applicable and any non-covered charges. Our office will do the billing for your insurance as required.

Private Patients: We participate in many private insurance plans. This means that we accept the amount that these insurance companies **approve** as our full fee. You are still responsible for any co-payments, Deductibles, share of costs and/or non-covered services.

You will receive a statement from this office as long as your account has an outstanding balance. This will show you all charges, payments, and adjustments that have been posted to your account. It will also indicate whether or not we have billed your insurance. Please review your statement each month and notify our billing office immediately if you feel an error has been made or if you have any questions concerning your balance. CHMB, our billing office, can be reached at (760)520-1400.

Due to the nature of our medical specialty and our appreciation of the value of your time, it may be necessary in the event of an emergency or unforeseen delay to reschedule your appointment. We will always try to provide you with as much notice as possible and appreciate your patience and understanding. *Likewise, please give us at least 48 hours notice if you are unable to keep your appointment with us or you will be charged a "no show" fee of \$35.00.*

By signing below, you are acknowledging that you have read this policy, understand it, and agree to abide by its terms.

Signed: _____ Date: _____

SDCVA Appointment and Cancellation Policy

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Scheduled Appointments

For a scheduled appointment please call

Encinitas Office (for Dr. Avalos, Dr. Backman, Dr. Charlat, Dr. Du): (760) 944-7300

9834 La Jolla Office (for Dr. Effron, Dr. Hamzei, Dr. Carson): (858) 824-2900

9850 La Jolla Office (for Dr. Lucks, Dr. Carlos, Dr. Kulhanek): (858) 457-1234

Dr. Buchbinder's Office, please call (858) 625-4488.

How to Cancel Your Appointment

To cancel appointments please call the numbers above for a scheduler 24 hrs prior to your appointment time. If you do not reach someone you may leave a detailed message on the voice mail with the schedulers. You may not cancel via email or mail.

Late Cancellations

Late cancellations will be considered as a "no show".

No Show Policy

A "no show" is someone who misses an appointment without canceling at least 24 hrs prior to the appointment time. **The patient will be charged a "no-show" fee of \$35.00 per appointment excluding Nuclear test appointments.**

A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "no show". Three "no shows" will result in no further appointments scheduled until further notice.


Please note that Nuclear Test appointments have a different no-show policy.

Signature

Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS PROVIDER

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ **YES**, I authorize the practice to verbally release any or all information concerning my medical care to any family member.

OR

_____ **NO**, I do not authorize the practice to release any or all medical information to other than myself.

:*****

_____ **YES**, I authorize the practice to verbally release any or all information concerning my medical care on any personal answering machine/voice mail or via e-mail

OR

_____ **NO**, I do not authorize the practice to verbally release any or all information concerning my medical care on any personal answering machine/voice mail or via e-mail

EXCEPTION TO: Use ONLY if you (X) NO above.

 Name

 Relationship to Patient

 Name

 Relationship to Patient

 Patients Signature

 Date

 Witness

 Date

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**AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL
RECORDS FROM MEDICAL PROVIDERS**

I understand this consent is valid indefinitely as part of my medical treatment with San Diego Cardiovascular Associates.

I hereby authorize **SAN DIEGO CARDIOVASCULAR ASSOC.** to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past. This would include receiving these records via fax.

I understand that as a part of **SAN DIEGO CARDIOVASCULAR ASSOC.** treatment, billing, or health care operations, it may become necessary to disclose medical information to referring physicians, hospitals, and any insurance company, third party administrator, or managed care company. This would include disclosures via fax., e-mail or internet.

PLEASE SIGN:

Patient Signature

Date

Printed Name

Date of Birth

San Diego Cardiovascular Associates
320 Santa Fe Dr. #204
Encinitas, CA 92024
760-944-7300 Fax 760-633-3949

FAX

Patients Name: _____ DOB _____

Attn Patient: Please fill out this fax cover page authorizing release of your medical records and give it to your referring or primary care doctor. We must have your medical records in order to better serve you. Your appointment will be significantly delayed without these records.

AUTHORIZATION FOR RELEASE OF INFORMATION

Referring or Primary Doctor: _____

I authorize the following medical records to be released to San Diego Cardiovascular Associates BEFORE my appointment so that the cardiologist will have my records to better serve me.

- Most recent progress notes
- Referral information
- Most recent EKG
- Patient registration ad copy of insurance card
- Most recent lab results
- Other: _____

Patient Signature: _____ Date: _____

Name of my cardiologist: _____

Date of my appointment: _____

Fax medical records to: San Diego Cardiovascular Associates
760-634-6564
Attn: Scheduling Department