

**Citrus Cardiology Consultants, PA.**  
**Financial Policy**

We are committed to providing you with the best possible medical care. In order to achieve this goal we need your assistance and understanding of our payment policy.

**Payment for service is due at the time service is rendered.**

- We accept cash, personal checks, debit cards, VISA and Mastercard.

**Cancelled appointments**

- Patients who do not call to cancel appointments may be discharged from the practice after the third “no show”.

**Blue Shield of Florida**

- Our physicians participate with the following programs: **Traditional Insurance Program, Network Blue, PPC, Medicare Advantage PPO, HMO, and Medicare Supplemental** programs. Your co-pay is due at the time of service.

**Medicare**

- Your deductible and 20% of the allowable charges are due at the time of service.

**Financial Agreement**

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g., yearly exams).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **All charges are your responsibility from the date services are rendered.** Any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such a situation does occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable cost of collection, including attorney's fees whether suit is filed or not.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

**I have read and understand the above financial policy.**

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**Signature**

**Date**

**LIFETIME AUTHORIZATION INSURANCE ASSIGNMENT'S AND AUTHORIZATION  
TO RELEASE INFORMATION**

I. RELEASE OF INFORMATION - I the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT -I, the below named subscriber, hereby authorize payment directly to any physician examining me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for their services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay the deductible amount, co-insurance, or any other balance not paid for by insurance or third payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Date: \_\_\_\_\_ Patient: \_\_\_\_\_

SUBSCRIBER (if different from patient):

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

**MEDIGAP (SECONDARY INSURANCE) SIGNATURE**

NAME OF BENEFICIARY	HEALTH INSURANCE COMPANY	MEDIGAP POLICY NUMBER

I request that payment of authorized MEDIGAP benefits be made on my behalf to \_\_\_\_\_ for any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release to \_\_\_\_\_ any information needed to determine benefits or the benefits payable for related services.

**SUBSCRIBERS SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# Patient Information Sheet

**Please Print Clearly**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
                            First                    Middle                    Last

**Please circle correct answer:**

**Sex:** Male / Female                      **Marital Status:** Single / Married / Divorced / Other  
**Is this an Auto Accident Claim?:** Yes / No              **Is this a Workman's Comp Claim?** Yes / No

Mailing Address: \_\_\_\_\_

Street Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Phone # for Northern Address (if applicable): \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Are you Employed?: Yes or No (please circle one) Retirement Date: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Person who does not live with you for emergency contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Primary Insurance**

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

## **Secondary Insurance:**

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

**\* Copies of Insurance Cards are Required \***

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE	INITIALS	REASON