Name:_____ DOB:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of Colorado Heart & Vascular, PC's Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Colorado Heart & Vascular, PC's privacy practices or my rights with regard to my personal health information, I may contact your Compliance Officer at: 11700 W. 2nd Pl. Ste 350, Lakewood, CO 80228, 303-595-2727 for further information as set forth in the notice.

Printed Name of Patient or Patient Representative	Patient's Date of Birth
Signature of Patient or Patient Representative	Date

If signed by Patient's personal representative, State Representative's authority to act on behalf of the patient.

*****STAFF USE ONLY*****

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Patient's Date of Birth: _____

I hereby certify on _____/_____/_____ (MM/DD/YR), I made a good faith effort to obtain the above patient's written acknowledgment of receipt of Colorado Heart & Vascular, PC's Notice of Privacy Practices, but I was unable to do so for the following reason(s).

_____

_____

_____

Name of Staff Person

_____ _____

Signature of Staff Person Date

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.

Colorado Regional Health Information Organization

Colorado Heart & Vascular, PC endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your healthcare providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

Name:_____ DOB:_____

Primary Insurance Information

Insurance Name:_____ Phone: _____

Address: _____ City: _____State: _____ Zip: _____

Member ID/Policy #: _____ Group #: _____ Copay: _____

Primary Policy Holder Name: Last: _____ First: _____

Date of Birth: _____/_____/ _____SSN: _____ - _____ -_____ Sex: M F

Relationship to Patient _____

Secondary Insurance Information

Insurance Name:_____ Phone: _____

Address: _____ City: _____State: _____ Zip: _____

Member ID/Policy #: _____ Group #: _____ Copay: _____

Primary Policy Holder Name: Last: _____ First: _____

Date of Birth: _____/_____/ _____SSN: _____ - _____ -_____ Sex: M F

Relationship to Patient _____

Emergency Contact (not at same address): _____ Relationship:_____

Home Phone: (_____)_____ Work: (_____)_____ Cell: (_____)_____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/ or surgical benefit for services rendered by Colorado Heart & Vascular, P.C. to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Colorado Heart & Vascular, P.C.

I understand that I am financially responsible for the amount not covered by insurance including, co-payments, co-insurance, and deductibles. I also agree that it is my responsibility to understand my insurance coverage and to verify that appropriate referrals, or pre-authorizations required by my insurance coverage are in place before the service is rendered. A photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release information necessary to secure payment. The assignment will remain in effect until revoked by me in writing.

Signature of Patient or Authorized Representative

Date

Name:_____ DOB:_____

Colorado Heart & Vascular

Professionalism Taken to Heart

Thank you for choosing us as your Specialist care provider! We are committed to providing you with premium quality, affordable health care.

INSURANCE We participate in most insurance plans, including Medicaid and Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility.
Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYS & DEDUCTIBLES All co-payments and deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.Please help us in upholding the law by paying your co-payment at each visit. If you have an insurance plan with a high deductible or a plan with a co-insurance, please be advised that you may be responsible for paying your insurance provider's portion (roughly half of what we bill them) until that deductible has been met. Due to the many varying complexities of each insurance plan, we are only able to provide you with an ***ESTIMATE*** of what you may owe. If in the event that you have a high deductible plan you may still have a remaining patient balance due for each visit.

NON-COVERED SERVICES Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

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 a 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.

UNVERIFIED INSURANCE COVERAGE Our office staff will attempt to verify each patient's insurance coverage at the time of service. If we cannot verify your coverage at the time of service, you will be required to pay $150.00 prior to your appointment. Once your insurance payment has been received, any remaining credits will be credited back to the card on file.

CLAIMS SUBMISSION We will submit your claims and assist you in any way we reasonably can 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. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Name:_____ DOB:_____

COVERAGE CHANGES If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

NONPAYMENT If your account is over 180 days past due for office visits, your account will be placed in collections. If your hospital account is over 90 days, you will be placed in collections. Payment plans are available and MUST be set up through the billing office. Our billing company is Aegis and their phone number is 1.888.295.3004. Please be aware that if a balance remains unpaid, we may refer your account to an outside collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

MISSED APPOINTMENTS Our policy is to charge $50.00 for missed appointments not canceled 24 hours prior to scheduled time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

RETURNED CHECKS Should your check be returned for any reason, you will be assessed a $50 returned check charge. All future balances will be payable with credit or debit card ONLY.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy, and please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Patient Name:_____ Date:_____

Patient Signature:_____