BLUE RIDGE
Cardiovascular Associates

PATIENT ACKNOWLEDGEMENT OF OFFICE POLICIES

Zia Roshandel, M.D., F.A.C.C.

Insurance Information – Co-payments, Co-insurance, Deductibles and Balance Owed
Blue Ridge Cardiovascular Associates will file your claim with your insurance if we participate with your insurance plan; otherwise, payment is required in full for all services at the time they are rendered. Should any services not be covered by your insurance, you agree to accept financial responsibility for said services. All applicable co-payments, co-insurance and deductibles and balance owed on your account are to be paid in full and collected at each and every visit. If you have not made arrangements with our Billing Department, prior to your visit, you will be asked to reschedule your appointment.

Patient statements will now be mailed to you every fifteen days. If you have not paid your balance owed to us by the tenth day after the third statement is due, your account will be placed with our collection agency. At that time, your account will be assessed a 31% fee on the balance owed, for which you are responsible to pay, along with the balance owed on your account.

If you have made arrangements with our Billing Department for a payment plan, you will be required to make your installment payment every month. In the event that you miss one payment, your account will be placed with our collection agency. At that time, your account will be assessed a 31% fee on the balance owed, for which you are responsible to pay, along with the balance owed on your account.

In the event of a default on any payment due to Blue Ridge Cardiovascular Associates, you will agree to pay all costs of collection (31%), including any attorney fees (33 1/2%). Returned checks are subject to a $30.00 administrative fee. Your signature below signifies your understanding and willingness to comply with this policy.

Referral Information
If a referral is required by your health insurance plan, it is your responsibility to obtain the referral from your Primary Care Physician and assure it is available to be presented at the time of your visit. Additionally, it is your responsibility to keep track of the number of visits you have used on your referral, the expiration date of your referral and obtain new ones as needed. Should you fail to have a valid referral for your visit, insurance regulations require that you sign a financial waiver. Your signature below signifies your understanding and willingness to comply with this policy.

Insurance Cards and Photo Identification
All patients are required to provide valid insurance card(s), or a temporary print out at the time of their visit. Should you be unable to produce this documentation, insurance regulations require that you sign a financial waiver. All patients are also required to provide photo identification. Your signature below signifies your understanding and willingness to comply with this policy and that you are responsible for notifying our office of any changes to your insurance or contact information.

Cancellation Policy
We require a 24-hour notice to cancel or reschedule the appointment that has been reserved for you. If you do not provide a 24-hour notice, you may be charged a fee of $50 for an office visit appointment and $100 for any testing procedure visit such as an Echocardiogram or Stress Test. Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations and "no-shows." These fees are not reimbursable by your insurance company.

Virginia Law (Section 32.1-45.1 et.seq.)
I understand that if, during the course of care, a health provider is directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B or C or AIDS, for the protection and well-being of the health care provider, it is important that a test be made on my blood without charge to determine whether I am carrying the virus and that under Virginia Law (Section 32.1 – 45.1 et. seq.) I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider. I also understand that health providers are deemed to consent to tests and the release of the results to me, should I be similarly exposed.

HIPAA Policy
Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Blue Ridge Cardiovascular Associates from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information.

Name Of Individual	**Relationship To Patient**

May we release Medical Information to: _____ Voice Mail At Home _____ Voice Mail At Work _____ Voice Mail On Cell Phone

Name of Patient:_____ Date Of Birth:_____

Parent/Guardian's Name If Patient Is A Minor_____ Date Of Birth:_____

Signature of Patient or Parent/Guardian:_____ Date:_____