Cardiovascular Specialists of Central Maryland
A Community Specialty Practice of Johns Hopkins Medicine
10710 Charter Drive, Suite 400
Columbia MD 21044

PATIENT FINANCIAL POLICIES

Revised as of September 1, 2016

Cardiovascular Specialists of Central Maryland is committed to providing our patients with the best in consultative and diagnostic cardiac care. In order to continue to provide our patients with the high standards of care and expertise they have come to expect, it is important that we work together to ensure accurate billing and timely payment for our services.

The financial policies on the following pages outline our mutual responsibilities in this process.

PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

It is critical that we have correct demographic (personal) information about you and about your health insurance coverage in order for us to bill accurately for the services we provide to you. This information includes:

- Your complete name, address, and contact phone numbers;
- The name of your insurance company, the group and subscriber number or other identifying numbers;
- Your insurance company's claims filing address and telephone number;
- A COPY of your insurance card, which also shows important information about your plan; and
- The name of the physician (usually your PCP, or Primary Care Physician) who is referring you to our office.

At each visit, we will verify your demographic information and may scan a copy of your driver's license or other valid photo ID and, for patients with insurance, your current in-force insurance card for your primary and secondary insurance. This is to ensure accurate billing information and to protect you by confirming that we are providing services to the correct individual. Please understand that our staff will ask for this information and these documents even if you have recently been seen in our office – **you may know us well, but our reception staff assist up to 200 patients a day and may not remember your specific information from your last visit**. If you do not provide us with the needed information in a timely manner, you may be responsible for payment for services rendered.

CANCELLATIONS AND MISSED APPOINTMENTS

Please notify us as soon as you know you will not be able to keep your appointment. Short-notice cancellations and missed appointments or "no-shows" prevent us from offering the appointment to other patients wishing to be seen, particularly for testing slots. Appointments cancelled two business days or less in advance (for example, on Thursday or Friday for a Monday appointment, on Monday or Tuesday for a Wednesday appointment, etc.) are considered "late" cancellations. A frequent pattern of appointment cancellations and/or visit "no-shows" makes it impossible for our providers to provide appropriate continuity of care, and **may result in a patient's discharge from our care.**

APPOINTMENT CANCELLATION FEES

For patients scheduled for nuclear stress tests, the radioisotope for your test is ordered specifically for you, and cannot be used for another patient. The radioisotope can cost several hundred dollars, with the exact cost varying depending on the dose required by the particular patient. This cost is not covered by your insurance when you cancel or are a no-show for your appointment. Therefore, patients who do not cancel at least three business days in advance are subject to a **$200.00 cancellation fee for the radioisotope dose, which must be paid before the test is rescheduled.**

For all other testing appointments, such as treadmill stress tests, echo, stress echo, and vascular studies, patients who do not cancel at least three business days in advance are subject to a **$50.00 testing cancellation fee, which must be paid before the test is rescheduled**.

RELEASE OF MEDICAL INFORMATION

Under Federal HIPAA regulations, we will release information from your medical record to your insurance carrier if required in order to process our claim for services we provided; to your primary care physician or other referring or treating physician(s) to provide continuity of care; and in certain other circumstances specifically permitted by HIPAA rules, without prior written authorization from you.

If you wish to have us release information from your medical record to other individuals or organizations, you will need to sign an authorization specifying the information to be released and to whom it is to be released. There may be a charge for release of information in certain circumstances; for example, for life insurance applications or legal proceedings, among other circumstances. Through our Patient Portal at https://cscm-columbia.gemmsportal.com/, you may view and download certain documents from your own medical record directly, without completing an authorization form or contacting our office.

COMPLETION OF FORMS

We regret that we are unable to complete forms during your office visit. There is a $20.00 charge, payable in advance, for completion of each form, and we require a minimum of five (5) business days for processing, although we will make every attempt to complete your form sooner. Please allow sufficient processing time before the form is needed.

Please also be aware that if you are requesting completion of disability and/or FMLA forms, and the reason for the disability and/or FMLA is not cardiac in nature, we will not be able to complete the form.

PATIENTS WITH INSURANCE COVERAGE

Insurance Plans With Which We Participate - We are participating providers with many of the major commercial and managed care insurance plans; with traditional Medicare (but NOT with any Medicare Advantage plans EXCEPT Johns Hopkins Advantage MD and Advantage MD Plus); with "regular" Maryland Medical Assistance, and with the Priority Partners Medicaid HMO plan. For questions about whether we participate with or accept your insurance plan, please contact our Business Office for assistance.

HMO Plans - If your insurance carrier is an HMO plan with which we do not participate, but your plan includes an out-of-network option, we will be happy to schedule you for a visit or diagnostic test. However, you will need to sign a waiver acknowledging that we are non-participating and agreeing to be responsible for payment of amounts not paid by your plan. You may have a deductible, higher copayments and/or coinsurance – meaning you have a higher amount you have to pay – than if you were to see an "in network" provider.

If we do not participate with your HMO plan and your plan does not have an out-of-network option, we are unfortunately not able to see you for any services in our office.

Verification of Insurance Coverage - We will verify your insurance coverage, including Medicare and Medical Assistance, at the time your visit or test is scheduled, and again shortly before your scheduled appointment. If we are not able to confirm active coverage, you will be considered "self-pay." It may be necessary to reschedule your visit or test if we are unable to verify your coverage.

REFERRALS AND PRE-AUTHORIZATIONS FOR SERVICES

Referrals - Your insurance plan may require a referral from your primary care physician (PCP) in order for us to see you for a visit or for diagnostic test services. **Under the terms of your coverage, it is your responsibility to obtain the appropriate referral prior to your visit.**

If your plan requires referrals and you do not have a valid referral at the time of your visit, we will need to reschedule the visit for another date so that you may obtain a referral from your PCP. Please make sure to contact your

PCP in a timely manner to obtain needed referrals prior to your visit (check with them to find out how much advance notice they require to prepare the referral, and if they need to see you for a visit before they will issue a referral).

Insurance Pre-Authorizations - In some cases an additional approval called a **pre-authorization** or **pre-certification** is required by your insurance carrier for certain diagnostic tests. We will advise you of this requirement when you request an appointment, and will work with your PCP's office and/or your insurance carrier as needed to obtain the required pre-authorization before confirming an appointment for the requested test.

NON-COVERED SERVICES

Sometimes the tests or diagnostic procedures recommended for you by our providers may be determined to be non-covered or may be considered "not medically necessary" based on the benefits provided by your specific insurance plan. You will be financially responsible for the costs of non-covered services and services that your insurance carrier declines to cover as "not medically necessary."

If our information indicates that a specific service or services may not be covered by your plan, you will be asked to sign an ABN, or Advance Beneficiary Notice, outlining the services that we have determined may not be covered by your plan, and for which you agree to be responsible for payment, before we will provide those services to you.

PAYMENT OF COPAYMENTS AND DEDUCTIBLES

Copayments - You are responsible for paying your **copayment** at the time of each office visit and diagnostic test visit. We are unable to bill you for your visit copayments in lieu of payment at the time of your visit. **If you are unable to pay your copayment at the time of your visit, we will need to reschedule the visit for another date.**

Deductibles – Most commercial and managed care insurance plans also include an annual **deductible** amount that must be paid by the patient before the plan pays any benefits, and many people now have **high-deductible health plans (HDHPs)**, with annual deductibles that can be thousands of dollars. If you have not met your deductible, payment will be expected at the time of service. **If you are unable to pay your applicable deductible at the time of your visit, or to make approved payment arrangements after speaking with a Business Office representative, we will need to reschedule the visit for another date.**

AMOUNTS DUE FROM YOU

We offer several options for payment of amounts due from patients who do not have insurance ("self-pay" patients), as well as for those patients who may have a large self-pay balance after insurance due to deductibles and/or coinsurance for which they are responsible.

How to Pay – Patients with self-pay balances receive monthly statements, with payment due upon receipt. We accept cash, personal check, and Visa, MasterCard, Discover and American Express credit and debit cards, as well as FSA, HRA and HSA debit cards, for all patient payments (please do not send cash payments through the mail). In the event of a returned check, a $30.00 service charge will be added to your account to cover fees assessed by our bank.

Discounts for Self-Pay Patients – For patients without insurance who elect to make payment at the time of service (office services only), we are able to offer a significant "prompt pay" discount. Please contact our Business Office for information on prompt pay discounts and payment amounts.

Partial Payments and Payment Plans - In certain circumstances, we are able to approve a partial payment at time of service and set up a payment plan for the balance. Please contact our Business Office for further information.

Reductions Due to Financial Need - You may be eligible for a reduction in your self-pay balance, including self-pay balances after insurance, in cases of documented financial need. Please contact our Business Office if you would like us to send you a Financial Assistance Application.

Self-Pay Balances After Insurance - If you have insurance but have a balance remaining after your insurance carrier processes the claim, you will receive a statement from our office showing itemized charges, insurance payments and adjustments, any patient payments, and remaining balance due. Payment is due upon receipt, and may be made by personal check or credit card as listed above (please do not send cash through the mail.)

Refunds - In the event a patient payment results in an overpayment or "credit balance" on your account, the overpayment will be refunded to the patient as soon as all payments posted to the account have been verified and any unpaid dates of service have been resolved.

NON-PAYMENT / DELINQUENT ACCOUNTS

Please contact us if you find that you are having difficulty meeting your payment obligations. If you do not communicate with us, we cannot work with you to determine potential eligibility for a reduction in your account balance and/or to establish a reasonable payment agreement.

If the self-pay balance on your account is 60 days or more past due, if you do not contact us about your balance or respond to our efforts to contact you, and/or if you do not make agreed-upon payments when we have approved a short-term payment plan, *your account balance will be subject to placement for outside collection*. If your account balance is placed for outside collection, the unpaid amount will be reported to credit bureaus by our contracted collection agency. You will be responsible for all reasonable collection and attorney fees and filing and processing costs. Additionally, once an account balance is placed for outside collection, that balance is no longer eligible for consideration for financial assistance. In extreme circumstances, an unpaid account balance may result in a patient's discharge from our care.

FOR FURTHER INFORMATION AND ASSISTANCE

If you need assistance or have further questions, **please contact our Business Office Financial Coordinator at (443) 276-9049 between 8:30 am and 4:30 pm Monday through Friday**, or send us a message through our Patient Portal, which is a secure, HIPAA-compliant method to communicate with our office, at https://cscm-columbia.gemmsportal.com/ at any time. We will make every effort to resolve your questions.