



# C.A.I. A Cardiovascular & Arrhythmia Institute

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## Policy and Procedures of CAI

We would like to take this opportunity to welcome you to our office. The following document will outline our policies and procedures relating to our financial policy. Please take some time and read this document.

### HEALTHCARE REQUIREMENTS:

The Institute specializes in your complete Cardiovascular Care, including Electrophysiology and heart arrhythmias. We believe in providing you with the best possible care and working as a team with your family physician, internists, other cardiologists and/or any other specialists to help you with the latest care in healthy living.

### PAYMENT AT THE TIME SERVICE IS RENDERED: \_\_\_\_\_ initials

Payment is required at the time services are rendered. We would appreciate your co-pays, deductibles, and/or patient non-insured portion at the time of the visits, if we participate with your insurance plan. This policy allows us to balance your account to zero when the insurance check arrives and saves you from receiving numerous monthly statements. We accept cash, personal checks, and MasterCard or Visa. For all returned checks an additional \$25 fee will be assessed and incurred by the writer per check.

### BILLING PROCEDURES: \_\_\_\_\_ initials

As you visit our office requesting medical care, you undertake a personal obligation and responsibility for your account. All statements are mailed out monthly. We ask that you pay balances off monthly, (unless other arrangements have been made), and we regard any account over 90 days old as a matter of collection.

### COLLECTION PROCESS: \_\_\_\_\_ initials

If any account does advance to collection and/ or litigation, the patient is financially responsible for all costs that might be incurred in collection said account, i.e. attorney fees, court costs, filing fees etc.

### INSURANCE REFERRALS:

For any contracted insurance plans that require a referral form, we must ask that the referral form be brought in with you at the time of the appointment. We will not await the referral by mail. If we do not have the referral form at the time of your appointment, your appointment will be rescheduled unless you are willing to pay in full that day.

Policy and Procedures of CAI- Continued

### TREATMENT ESTIMATES:

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[www.caiaz.com](http://www.caiaz.com)

Phone 480.889.1573

Fax 480.889.1574



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New patient visits take more time than return visits, therefore the charges are typically higher. You may feel free to discuss our fees with the billing office at any time. In addition, other testing may need to be performed; therefore the final charges may be more than what was originally estimated.

### ADDRESS AND INSURANCE CHANGES:

Please keep us informed of address, telephone number, employment, or insurance changes.

### INTEGRITY AGREEMENT:

Both parties desire to have a method of resolving discomfort, misunderstanding, or disputes. If any of these previously mentioned occur, please bring it to our attention privately, quickly, and in a friendly manner. We agree to resolve these matters using the communication, mediation, and arbitration procedures set forth in the latest edition of the standard Law Forms Integrity Agreement. (This in no way relinquishes your possibilities of seeking legal counsel.)

### SPECIAL NEEDS:

We are here to help you. If you have special needs or circumstances that may require a payment plan, please feel free to discuss this with us as early as possible.

### CANCELLATION OF APPOINTMENTS: \_\_\_\_\_ initials

We require a 24 hour cancellation notice of all scheduled appointments. Any appointments not cancelled within a 24 hour time frame will be subject to a cancellation fee.

Thank you for taking the time to read this policy and procedures statement. We hope that it answers any questions that you may have regarding the Institute's financial policies.

### Patient's Declaration:

I have read and understand this policy statement. I understand that I am financially responsible for charges incurred and I authorize my insurance carrier to pay benefits to CAI Cardiac Arrhythmia Institute, LLC. All of my questions and concerns have been answered.

Signed \_\_\_\_\_  
(Name)

Signed \_\_\_\_\_  
(Guardian- if applicable)

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