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: _____ **initials**

I authorize the above stated physician, his associates, assistants, and other qualified medical personnel of his/her choice to treat me and to recommend and/or order laboratory tests or other specialized tests as indicated for diagnosis for my medical condition. 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.

BILLLING 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: _____ **initials**

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: _____ **initials**

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. Please know we are only given an estimate from your insurance company and this is subject to9 change.

ADDRESS AND INSURANCE CHANGES: _____ **initials**

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

INTEGRITY AGREEMENT: _____ **initials**

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_____ **Signed**_____
(Name) **(Guardian- if applicable)**

Date: _____

YOUR RIGHTS PURSUANT TO ARIZONA ADMINISTRATIVE CODE, TITLE 9, CHAPTER 10, ARTICLE 9 AND 10:

1. A patient is treated with dignity, respect, and consideration.
2. A patient is not subjected to:

    A. Abuse; neglect; exploitation; coercion; manipulation; sexual abuse or assault.
    B. Restraint or seclusion, except as allowed in R9-10-1012(B) if the center is authorized to provide behavioral health observation/stabilization services.
    C. Retaliation for submitting a complaint to the Arizona Department of Health Services or another entity; or
    D. Misappropriation of personal and private property by the center's personnel members, employees, volunteers, or students; and

3. A patient or the patient's representative has the right to:
    1. Consent to or refuse treatment, except in an emergency.
    2. Refuse or withdraw consent for treatment before treatment is initiated.
    3. Be informed of:
        i. Except in an emergency, alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure.
        ii. Policies and procedures on health care directives; and
        iii. The patient complaint process
    4. Consent to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to the center for identification and administrative purposes.
    5. Except as otherwise permitted by law, provide written consent to the release of information in the patient's medical record or financial records.
4. A patient has the following rights:

    A. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
    B. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
    C. To receive privacy in treatment and care for personal needs.

D. To review, upon written request, the patient's own medical record according to ARS 12-2293, 12-2294 and 12-2994.01.

E. To receive a referral to another health care institution if the center is not authorized or not able to provide physical health services or behavioral health services needed by the patient.

F. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment.

G. To participate or refuse to participate in research or experimental treatment; and

H. To receive assistance from a family member, representative or other individual in understanding, protecting, or exercising the patient's rights.

5. These rights are also available as a separate document: Arizona Patient Rights and Responsibilities (PDF)

6. Fees for services are available upon request and can be provided by management.

7. State survey results available upon request with the Arizona Department of Health, phone number 602-364-3030.

I understand these rights and know I am encouraged to contact the Administrator should I have any questions or concerns.

Signed_____ **Signed**_____

(Name) **(Guardian- if applicable)**

Date: _____