Virginia Heart & Vascular Institute

Patient Name: _____ Date: _____
Print First and Last Name

I, the patient, understand that:

- ✓ Our office highly recommends that you know the benefits covered by your medical insurance. This includes, but is not limited to, referrals for our office, as well as other outside services (i.e. x-rays, hospitals, etc), co-pays, pre-authorizations, injections and other medications administered in the office.
- ✓ If a referral is required from my primary care physician, it is up to me to bring a valid referral to my appointment. Failure to do so will result in me being financially liable for my visit or my appointment will be rescheduled when the referral is presented.
- ✓ Co-payment and/or deductible is required PRIOR to service.
- ✓ It is my responsibility to inform the office of any change in my address or insurance information prior to any visit. Failure to do so could result in patient liability should any issue arise.
- ✓ All follow-up appointments require 48-hour notice to cancel or reschedule. There will be a charge of $25 for the first broken appointment, $50 for the second, and $75 thereafter.
- ✓ **All vein procedure and nuclear stress test appointments require 48-hour notice to cancel or reschedule. Failure to do so will result in a charge of $150. If Pre-authorization is obtained by our office and any of the appointments are cancelled, there will be a charge of $150 per procedure.**
- ✓ Services are only provided if they are medically necessary and pre-authorization will be obtained if required. Any denied claims that are not resolved after a second level appeal will be my financial responsibility.
- ✓ There is a 48- to 72-hour turnaround time for all letters or notes requested from the doctor or staff.
- ✓ There will be a fee charged for the completion of any disability or medical status forms that are requested to be completed by this office. The fee will be in accordance with time involved and the number of medical records copied. Please ask about this fee when presenting the document to be completed.
- ✓ There is a standard $25 fee charged when requesting medical records be sent to a Secondary Institute for a second opinion or consultation.
- ✓ I acknowledge that I have read and understand the above office policies and conditions.

Patient Signature: _____

Patient Date: _____