BLUE RIDGE CARDIOLOGY AND INTERNAL MEDICINE, PA
"Our" BLUE RIDGE MEDICAL GROUP

BILLING OFFICE
PO BOX 249
YADKINVILLE, NC 27055
336-679-4963

PRACTICE LOCATIONS
111 Comer Street, Dobson, NC 27017
905 Rockford Street, Mt. Airy, NC 27030
380 Parkwood Medical Park, Elkin, NC 28621
640 Parkwood Medical Park, Elkin, NC 28621
108 South Street, North Wilkesboro, NC 28659
1909 West Park Drive, North Wilkesboro, NC 28659
665 South Main Street, Trojan Village #206, Sparta, NC 28675

FINANCIAL POLICIES

This is an agreement between Blue Ridge Cardiology & Internal Medicine, PA (creditor) and the Patient/Guarantor (debtor) named in this agreement. In this agreement the words "you, your and yours" mean the Patient/Guarantor (debtor). The word "account" means the account that has been established in the patient's name to which charges are made and payments credited. The words "we, us and our" refer to Blue Ridge Cardiology & Internal Medicine, PA.

By executing (signing) this agreement you (Patient/Guarantor) are agreeing to be responsible for payment of all services that are rendered by providers of this medical group. A guarantor is required for all children under the age of eighteen years.

Co-Pays, Co-Insurance and Deductibles: If you have insurance with a company or government agency with which we are contracted, any co-payments, co-insurance or deductibles required by your insurance company must be paid at the time of service. If you are unable to make your co-payment at the time of your scheduled appointment you may be asked to reschedule your appointment. If you have insurance with a company with which we are not contracted, we will file your insurance but we will not take any adjustments and you are responsible for any balance not paid by the insurance company.

Discounts: If you do not have insurance and have no outstanding unpaid balance with us you may be eligible for a 20% discount by paying in full at the time of service.

Missed Appointments: We require 24-hours advance notice of cancellation or re-scheduling of appointments by you. The following fees apply for missed appointments:

1. Office Visits – Your account will be charged $25.00 for the missed appointment time if you fail to provide us with 24-hours' notice of cancellation or re-schedule.
2. Sleep Studies – Your account will be charged $200.00 for the missed appointment time if you fail to provide us with 24-hours' notice of cancellation or re-schedule. .
3. Cardiology Studies – Your account will be charged $50 for the missed appointment time, plus the cost of any medication we must order for the study, if you fail to provide us with 24-hours' notice of cancellation or re-schedule.

Worker's Compensation: We require written approval/authorization from your employer and worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Accident or Personal Injury: If you are being treated due to a personal injury lawsuit or a motor vehicle accident, payment will be your responsibility at the time of service. With proper authorization we will provide required information regarding your medical treatment but we will not become third-party to any legal action on your behalf.

Returned Checks: Your account will be charged a $25.00 return check fee for any check that is returned by the bank for insufficient funds. Repeated return checks will result in a requirement for payment in cash only.

Monthly Statement: If there is a balance on your account, we will send a monthly statement. It will separately show the previous balance, any new charges and any payments or credits applied to the account since the last statement.

Payments: Unless other arrangements are made with us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid within thirty (30) days.

Past Due Accounts: If your account becomes past due we will take the necessary steps to collect the debt up to and including legal action. If we have to refer your account to an outside collection agency, small claims court or an attorney you agree to pay all costs associated with the legal collection of the debt. Failure to pay your account or to make satisfactory payment arrangements with us may result in termination of the physician-patient relationship with you.

Waiver of Confidentiality: You understand and agree that if this account is submitted to a collection agency, credit reporting agency or an attorney for litigation, the fact that you received treatment at our office may become a matter of public record.

Transfer of Medical Records: If we choose to terminate the physician-patient relationship there is no cost to you for us to provide copies of your records to another physician/provider of your choice. If you choose to terminate the physician-patient relationship the cost of providing a copy of your records will vary depending upon the number of pages; however there is a minimum fee of $10.00. You will need to make your request in writing, either on a form from your new provider or one provided by us. The fee must be paid prior to releasing the records either to you or to your new provider.

Requirements for filing Insurance Claims on your behalf:
You are responsible for knowing your health insurance benefits, including deductibles, co-payments, co-insurance and if there are any exclusions to your policy. You are responsible for assuring that all referrals and/or authorizations are obtained for each visit.

We will file insurance claims for all services rendered to patients, including non-contracted insurance carriers. You will be expected to present a current copy of your insurance card(s) on each and every visit. For successful claim filing it is necessary that you provide us with accurate and current insurance and demographic information, an assignment of benefits and an authorization to release information.

Most insurance companies do not pay 100% of a claim. Non-payment of your claim by your insurance company does not relieve you of financial responsibility for the remaining balance. You understand and agree that ultimately you are responsible for any balance on your account, regardless of insurance status, and that non-payment of your account may result in the account being subject to collection agency or legal action. You certify that all information given is correct to the best of your knowledge and any changes to your information will be reported to Blue Ridge Cardiology & Internal Medicine, PA, as soon as it is known by you.

Release of Information and Assignment of Benefits:
I hereby authorize the release of any medical information necessary to process insurance claims on my behalf. I hereby assign payment of benefits to Blue Ridge Cardiology & Internal Medicine, PA, for any and all services rendered and claims filed by Blue Ridge Cardiology & Internal Medicine, PA. This authorization is valid from the date signed until written notice of cancellation is received or a new authorization is signed. I understand that I am responsible for any and all charges not covered or paid by this assignment

BY YOUR SIGNATURE YOU AGREE TO ALL THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT WILL BE IN FULL FORCE AND EFFECT UNTIL TERMINATED.

Patient Name (Printed)	Date of Birth	Medical Record Number

Patient or Guarantor (Printed)	(Signature)	Date Signed

Witness (Printed Name)	(Signature)	Date Signed