Miami Valley Heart & Lung Surgeons, LLC

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Policy and Procedure

TO: All Patients

FROM: MVHL Practice Administrator

TOPIC: Patient Financial Obligations

The following is Miami Valley Heart & Lung Surgeons, LLC (MVHL) policy regarding the payment for services rendered by members of this practice.

Policy: The members of MVHL surgeons will provide services to patients without regard to age, sex, sexual orientation, religious affiliation, race, national origin, and/or disability.

In return, it is the expectation of the members of the practice that the patient will provide all necessary information so that the practice can bill third party payors (Medicare, Medicaid and/or Insurance Company) efficiently and with the correct information.

The patient and/or responsible party will be required to sign an authorization for MVHL to bill for services provided. This authorization also designates MVHL as the sole agent to bill for services and receive payments for services provided by any physician or provider employed by MVHL surgeons.

Patient Financial Information:

- The patient is responsible for completing the "financial information" form provided by the practice completely prior to being seen in the practice. The patient is solely responsible for assuring the accuracy of the information provided.
- The patient is responsible for providing a copy of all third party coverage card(s) to the practice prior to being seen in the practice.
- The patient is responsible for calling the office with any changes in their insurance coverage information.
- The patient is responsible for assuring that all services provided are within network provisions of their policy coverage and will assume full responsibility for any penalties assessed due to non-network services that are provided.

Billing to Third Party Payors:

- The staff of MVHL will submit the necessary information for payment of services rendered to third party payer(s).
- The staff of MVHL will provide any requested support information (test reports, operative notes, etc.) to the third party payer(s) when required in support of the bills submitted.
- The staff of MVHL will process appeals for payment in cases where the third party payer(s) has denied services based on "medical necessity".
- The patient is responsible for processing any appeals for payment associated with "medical coverage".

Payment for Services Rendered:

- MVHL surgeons are "contract providers" for Medicare, Ohio Medicaid, Blue Cross/Blue Shield, United Health Care, Humana, Aetna, Cigna, Care Source, Medical Mutual of Ohio, Tri-Care and a number of other insurance coverage plans. MVHL agrees to accept payment as specified by these plans and/or in accordance with the laws of the State of Ohio, US Federal Government and principles established by the American Medical Association. As a contracted provider, we are required to collect all office visit co-pays, insurance co-pays and deductibles.
- As a courtesy, MVHL surgeons will bill other non-contract providers for the patient.
- The patient will pay any "office visit co-pays" at the time of service. In the event, the office visit copay is not made prior to receipt of the insurance company payment, the patient agrees to a "co-pay billing fee" of $10.00.
- Any balances that are the patient responsibility are due from the patient in full within 30 days of submission of the invoice from MVHL.
- Any account that is not paid within 30 days of invoice shall be subject to a "billing fee" of $10.00 per month.
- Should a patient refuse payment of any unpaid balances, MVHL surgeons will retain the right to turn the account over to a collection agency and/or attorney. All additional costs incurred by the practice to resolve the unpaid balance shall be added to the unpaid balance for medical services.
- Should a patient's third party payor not make payment within 60 days of submission of a bill for services, the unpaid balance will become the responsibility of the patient and subject to the other provisions contained within this policy.
- Any payments for services rendered by MVHLS or it's surgeons, received by the patient from the insurance company shall be submitted to MVHL surgeons within 7 working days. Failure to submit this payment as specified will result in a "billing fee" plus 0.5% of the unpaid balance per month.

Financial Hardship:

- In the event that the outstanding balance on a patient's bill cannot be paid due to financial hardship, the practice may be able to offer arrangements to resolve the bill. The patient is responsible for contacting the billing specialist or practice administrator to discuss these alternatives.
- In rare occasions, the financial hardship of the patient may be extreme. In these situations, a "financial hardship request" can be processed for consideration by the Financial Officer of the Corporation to assist in resolving the outstanding balance.

Misc. Forms Completion:

- FAMILY MEDICAL LEAVE FORMS – The practice will complete and have the surgeon sign the forms for the patient and/or family member(s) associated with time off of work. There is no charge for this service. Please allow 3 days for processing.
- DISABILITY FORMS (Private Insurance Company) – The practice will assist the patient in completing the forms associated with medical disability. There is a charge of $10.00 per form, payable in advance. Please allow 7 days for processing.
- SUPPLIMENTAL INSURANCE FORMS – The practice will assist the patient in completing the forms associated with insurance coverage for payment of bills while disabled (credit cards, revolving loans, mortgage, etc.). There is a charge of $10.00 per form, payable in advance. Please allow 7 days for processing.

Acknowledgement and Agreement:

I do hereby agree to and will abide by all specifications contained within this document. This agreement shall be in force for a period of one year from the initial date of service, without regard for where those services are rendered (hospital or office). This agreement may only be altered upon written acceptance by both parties (practice and patient).

Patient Signature: _____ Witness Signature:_____

Date: _____ Date: _____