SOUTHEASTERN CARDIOLOGY

Dear Patient,

Welcome to Southeastern Cardiology! We are thrilled that you have chosen our practice for your care and look forward to getting to know you. We would like to provide you with some basic policies that allow us to coordinate your care.

Our business hours are 8:30 to 12:00 and 1:00 to 5:00 Monday through Thursday.

SCHEDULING APPOINTMENTS & ARRIVAL TIME: Please call during the business hours listed above. We will do our best to schedule you promptly. Please always arrive 30 minutes prior to your scheduled appointment time – this will ensure a quicker triage process and keep your appointment on schedule. If you need to speak with a financial counselor, please plan to arrive 45 minutes prior to your scheduled appointment.

CANCELLATIONS: If you cannot keep your scheduled appointment, it is important that you notify us as soon as possible. A 24-hour cancellation notice is required for all appointments. Testing appointments (e.g. echo and stress) have associated fees for missed appointments without appropriate cancellation notice or late arrivals passed the allotted grace period (please see our Financial Policy for fee schedule). Three (3) missed appointments without proper cancellation (no show) may result in dismissal from the practice.

AFTER HOURS: We understand that issues may arise outside of our business hours – if you have a medical issue that warrants immediate attention, please proceed to the nearest emergency room. If you feel that the issue is not severe enough to warrant immediate treatment, please call the following business day to schedule an appointment.

MEDICATION REFILLS: NO refills or medications of any kind will be prescribed after hours. This includes holidays and weekends. If you are getting low on your medications, please contact your pharmacy at least one week in advance to alert them that you need a refill. Your pharmacy will then contact us to request the refill. You can also request refills via the patient portal. All medication refills are at the discretion of your physician and you may be required to come in for a patient visit before your next refill. Please plan accordingly.

HOSPITAL VISITS: Our medical team rounds at St. Francis Hospital, Piedmont Midtown, and Piedmont Northside. In the event that you are admitted to the hospital for a cardiac related illness, someone on our provider team will be available to see you. After you are discharged, our office will contact you to schedule a hospital follow up; as well as, any other necessary testing.

Southeastern Cardiology Associates takes a zero-tolerance position on any form of physical, verbal, or sexual abuse or harassment towards our employees, patients, and/or visitors. Video or audio recording of employees is strictly prohibited. Anyone displaying such behaviors will be asked to leave the practice and risks being discharged from the practice as a patient.

Thank you for the opportunity to provide you with exceptional medical care.

Sincerely,
The Team at Southeastern Cardiology

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NOTICE OF HIPAA POLICIES AND PATIENT ACKNOWLEDGEMENT FORM

I acknowledge that SEC follows the guidelines set forth by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that the practice may use my personal health information to help provide healthcare to me with regards to billing and payment and/or other health care options. There may be no other uses or disclosures of this information unless I permit. I do, however, understand that sometimes the law may require the release of this information without my permission. I also understand that my health information is private and confidential. I understand that Southeastern Cardiology Associates will strive to protect my privacy and preserve the confidentiality of my personal health information. I understand that SEC has established procedures that help them in protecting my personal health information. These procedures may include other signature requirements, written acknowledgement, authorizations, and reasonable time allowance for requested information. I understand there may be charges incurred for copying my health information and for non-routine information needs. I further understand that SEC will not use or disclose my health information without my authorization, except as described in this notice. My signature below indicates that I understand and agree with the above use of my protected health information and that I have received a copy of the HIPAA Privacy Rule.

My signature below authorizes Southeastern Cardiology Associates to obtain any medical records necessary to assist with the medical care of my behalf.

Date _____

Signature

_____

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CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

IMPORTANT: Do not sign this form without reading and understanding its contents. Please initial any Procedure and/or section of this form for which consent is granted.

During the course of my care and treatment, I understand that various types, diagnostic, or treatment procedures may be necessary. These procedures are performed by the physician or an assistant for the physician.

While usually performed without incident, there are potential risks associated with each of these procedures. It is not possible to list every risk for every procedure and this form will therefore list the most common possible risks. It is important to note that a simple act as taking a commonly used medication can rarely cause severe reactions that could lead to organ failure or even death.

If I have any questions or concerns regarding these procedures, I will ask my physician or his/her assistant to provide me with additional information. These procedures include:

_____Needle sticks such as shots, injections, or intravenous lines to administer fluids or medications. Material risks include, but are not limited to infection, infiltration (fluid from an IV leaking into tissue), disfiguring scar, nerve damage with possible loss of limb function. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

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Physical tests, assessments, and treatments such as internal body examinations, wound cleaning, and wound dressing. Material risks include allergic reaction and infection. Apart from using modified procedure and/or refusal of treatment, no practical alternative exists.

_____Drawing blood or bodily fluids with a needle or taking tissue samples (biopsy). Material risks include but are not limited to infection, damage to joint or organ, nerve damage, and bleeding.

_____Administration of medication whether orally, rectally, topically, or through the eye, ear, or nose. Material risks include, but are not limited to, allergic reaction, puncture, and perforation. Apart from varying the method of administration and/or refusal of treatment, no practical alternative exists.

_____Insertion of internal tubes such as scopes, catheters, drainage tubes, etc. Material risks include but are not limited to internal injuries, bleeding, infection, and difficulty urinating after long term catheter placement. Apart from external collection devices or refusal of treatment, no practical alternative exists.

I understand that SEC uses a Physician Assistants and Nurse Practitioners in our office for those levels of practice that have been approved by the Georgia State Board of Medical Examiners. Your Signature on this approval form conveys that you are in agreement with being treated by our mid-levels who act under our supervision.

I understand that:

- The practice of medicine is not an exact science and that NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any procedures; and
- The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the procedures, therefore, I agree to provide accurate and complete information about my medical history

I may be asked to sign additional required informed consent documents for specific procedures and tests. By signing this form:

- I consent to Healthcare Professional performing Procedures as they deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen and not known to be needed at the time this consent is obtained; and
- I acknowledge that I have been informed, in general terms, of the nature and purpose, the material risks and the practical alternatives of the procedures.

Date _____

Signature

_____

SOUTHEASTERN CARDIOLOGY

Financial Policy

Thank you for choosing Southeastern Cardiology Associates for your cardiovascular care. Our financial policy ensures clear communication regarding medical billing, insurance responsibilities, and payment expectations.

_____Insurance and Patient Responsibility

As a courtesy, we will file insurance claims on your behalf. It is your responsibility to provide accurate and current insurance information and to notify us of any changes to your coverage. Patients are responsible for obtaining any required referrals or authorizations before office visits or testing appointments. Our staff will assist whenever possible; however, obtaining these approvals ultimately remains the patient's responsibility.

If insurance information is not provided in a timely manner or claims cannot be submitted within 30 days due to missing or incorrect information, the balance may become the patient's responsibility. Patients are responsible for all co-payments, deductibles, co-insurance amounts, and any non-covered services. Southeastern Cardiology Associates cannot participate in disputes between patients and their insurance carriers regarding these patient responsibility amounts. You are responsible for keeping your address and phone number up to date.

_____Payment at Time of Service

Estimated patient responsibility amounts are due at the time of service. This may include but not be limited to: Co-payments, Deductibles, Co-insurance, or outstanding balances. Remaining balances after insurance processing will be billed to the patient and are due within 30 days of the statement date.

_____Insurance Estimates

Any estimate of patient responsibility provided by Southeastern Cardiology Associates is based on information available at the time of service and is not a guarantee of coverage or payment. Actual patient responsibility may change based on the final determination made by your insurance carrier, including the application of deductibles, co-insurance, co-payments, noncovered services, coordination of benefits, or other plan provisions. I understand that insurance estimates are not guarantees of coverage or payment and that I remain financially responsible for any balance determined after final insurance processing. Patients remain financially responsible for any balance determined by their insurance carrier after final claim adjudication.

_____Billing and Collections

Patient balances are expected to be paid in full within 30 days of the initial statement. If you are unable to pay your balance in full, please contact our billing office at 706-221-6116 to discuss payment arrangements. Approved payment plans require automatic recurring monthly payments and must be completed as agreed.

Account balances that remain unpaid after two billing cycles and do not have an approved payment arrangement may be transferred to an outside collection agency. An administrative fee of up to 25% may be added to accounts prior to being transferred for collection. Patients with accounts in collections may have future appointments delayed, cancelled, or restricted until financial obligations have been resolved, except as required by law or in emergency situations. The patient consents to communication by us and our authorized third-party collection vendors through phone, text message, email, or mail regarding the account.

_____Credit Card on File Authorization

For your convenience, Southeastern Cardiology Associates may securely maintain a credit card on file. By signing this policy, you authorize the practice to charge the card on file for:

- Patient balances after insurance processing
- No-show and late cancellation fees
- Returned check fees
- Other authorized charges permitted by law and insurance contracts

A receipt will be provided upon request. Payment plans require stored credit card information.

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Financial Policy Cont.

_____Refund Policy

Patient refunds will not be issued until all insurance claims have been fully processed and the practice has received final payment information from all applicable insurance carriers. Once all claims have been finalized, any verified overpayment will be refunded to the patient and mailed to the address on file.

_____Chargebacks and Payment Disputes

If you have a question or concern regarding a charge, please contact our office before initiating a chargeback or payment dispute through your financial institution. If a chargeback or payment dispute is initiated for charges that are determined by our office to be valid and authorized, the patient remains responsible for the balance due. False reports of fraud or unauthorized use will result in a police report being issued. Patients are responsible for all legal and collection costs incurred during recovery, as permitted by applicable law. An initiated chargeback does not dissolve responsibility for balance. Unresolved financial obligations may be considered when determining whether the practice can continue providing nonemergency services, subject to applicable law and practice policies.

_____Returned Check Fee

A $35.00 fee will be assessed for any check returned by the bank.

_____Forms and Medical Records

A $50.00 fee may be charged for completion of forms requiring provider review or completion. Medical record copy fees will be charged in accordance with applicable state and federal regulations. Any required fees must be paid before records are released.

_____Appointment Cancellation, No-Show, and Late Arrival Policy

Our office requires a MINIMUM of 24 business hours' notice. Please note that our call center is closed on Fridays. Fail to attend a scheduled appointment or arriving after the designated grace period may be charged. No showing a testing appointment or failing to pay assessed fee will lead to dismissal from the practice.
Vascular (late after 15 minutes), CPET Appointments (late after 15 minutes): $35.00
ECHO (late after 5 minutes): $35.00
Stress ECHO (late after 5 minutes): $500.00
Treadmill Appointment (late after 15 minutes): $50.00
Nuclear Appointment (late after 15 minutes): $100.00
PET Appointment (late after 15 minutes): $300.00
PYP/Amyloid (late after 15 minutes): $300.00
These fees must be paid in full before any appointment may be rescheduled. Fees are subject to change without notice.

Patient Acknowledgment

By signing below, I acknowledge that I have received a copy of, read, and understand this Financial Policy, including the policies regarding insurance billing, patient responsibility, payment obligations, collections, refunds, credit card on file authorization, chargebacks, and appointment cancellation/no-show fees. I agree to be financially responsible for all charges incurred under this financial policy.*

Patient Name (Print): _____
Date: _____
Signature:

*By voluntarily engaging with our medical practice our providers, and receiving treatment, you inherently accept the facility's basic terms of service such as consent for routine treatment, financial policies, and data privacy—even without a physical signature. Refusal to sign the financial policy requires management approval to schedule.

SOUTHEASTERN CARDIOLOGY

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE/DISCLOSURE OF PHI

FOR SEC STAFF USE ONLY:
TO: _____ **FAX:** _____
PLEASE SEND REQUESTED INFORMATION:
_____

PATIENT NAME: _____ **DOB:** _____ **LAST 4 SSN:** _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the facility where PHI is being requested from. I understand that my revocation is not effective to the extent that persons or organizations in which I have authorized to use and/or disclose my PHI have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility of benefits. I understand that I will be given a copy of this authorization upon my signature, when requested. I hereby authorize the facility where I am requesting PHI to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I hereby release the facility where I am requesting PHI from any liability which may result from this disclosure of confidential medical information of which may arise of the result of the use of information contained in the information released. I authorize this information may be faxed when applicable. I agree to pay copy charges if applicable.

I understand that this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted disease; human immunodeficiency (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

SPECIFIC INFORMATION NOT TO BE DISCLOSED:
_____

SEC WITNESS: _____ **DATE:** _____
SIGNATURE:

_____