CARDIOVASCULAR ASSOCIATES
OF CHARLOTTESVILLE
Quality Care in a Heartbeat

650 Peter Jefferson Parkway, Suite 100
Charlottesville, VA 22911

Office: (434) 293-4072
Fax: (434) 293-4265
www.cvilleheart.com

Patient Financial Responsibility Policy and Patient Assistance Program

Cardiovascular Associate's goal is to provide the best service possible. Please call us before your appointment if you need to make special financial arrangements to pay your bill.

1. General

a. The patient's insurance policy is a contract between the patient and his or her insurance company. However, **all charges are the patient's responsibility regardless of the insurance coverage** and the patient is ultimately responsible for any unpaid balances. As a courtesy to our patients, CVAOC bills the patients' insurance and makes every effort to ensure that claims are promptly and correctly processed. CVAOC also bills patients' secondary insurance when patients provide complete insurance information.

b. Patient co-pays are expected at the time of service, and any remaining payment is due in full within 30 days of receiving the first bill from CVAOC. We accept cash, checks, money orders, debit cards, and credit cards (VISA, MasterCard, Discover).

c. If you can't pay your balance within 30 days, please contact our Business Office at (434) 963-7016. There are several ways you can pay your bill, including possible payment plans, and a Business Office representative will help find the right one for your financial needs. We will also work with you to determine if you are eligible for financial assistance.

2. Past Due Balances. A past due balance is any amount owed after the insurance company has paid its portion, but where CVAOC has not received the full patient balance within ninety (90) days. After ninety (90) days as a private pay balance, interest may accrue at the rate of 1.0% per month (12% annual rate) on the unpaid balance at the discretion of the practice. Balances on accounts with payment plans where payments are in compliance with the plan are not considered past due balances. ***Patients who have a previous collection agency balance and wish to receive service are required to pay any new charges at the time of service.***

3. Payment Plans. Payment arrangements may be made on patients' accounts based on a review of circumstances and approval by the CVAOC Business Office. We generally do not extend payment plans to patients who have failed to make timely payments in the past. CVAOC's Business Office representatives may authorize monthly installment payments following the practice's minimum payment guidelines below:

Account Balance	Minimum Monthly Payment
$100 or less	$10.00
$250 or less	$25.00
$251 - $500	$45.00
$501 - $750	$65.00
$751 - $1000	$85.00
Over $1,000	10%

5. Waiver of Co-Pays and Deductibles

a. It is the policy of this practice to bill all applicable out-of-pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. CVAOC will not waive co-pay, coinsurance, or deductible amounts for insured patients, except in the limited circumstances set forth in this Patient Financial Responsibility Policy. Such determinations may be made only after sufficient investigation has been made and it is expected that such waivers will be *rare*.

b. If CVAOC does waive co-payments or deductibles for a patient based on the patient's financial status, we will maintain a record of the information upon which we based this decision. Waivers of co-pays and deductibles may also be made after reasonable collection efforts have failed to result in the collection of the fees. CVAOC will maintain records of what collection efforts have been made for fees waived in these instances.

c. Under no circumstances will our practice engage in any of the following practices with respect to the waiver or lowering of co-insurance and/or deductibles:

- Waive or lower co-insurance and deductibles that do not meet the requirements outlined in our Policy.

- Advertise, or in any way communicate to the general public that payments from private insurance, Medicare or Medicaid will be accepted as payment in full for health care services provided by our practice, or advertise or otherwise communicate to our patients or to the general public that patients will incur no out of pocket expenses.

- *Routinely* use patient assistance program forms which state that the patient is unable to pay co-insurance and deductible amounts.

- Charge Medicare beneficiaries or private insurance beneficiary's different amounts than those charged to other persons for similar services.

- Fail to collect co-insurance and deductibles from a specific group of patients for reasons unrelated to indigence or managed care contracting (e.g., to obtain referrals or to induce patients to seek care in my practice vs. another provider's practice who does not waive co-pays and/or deductibles).

- Accept "insurance only" or TWIP (take what insurance pays) as payment in full for services rendered.

- Fail to make a reasonable collection effort to collect a patient's balance.

6. Patient Assistance Program

a. For indigent, uninsured, or underinsured patients, Cardiovascular Associates may reduce or eliminate the patient's financial responsibility for medically necessary and appropriate

treatment on a case-by-case basis where the patient qualifies under our patient assistance program guidelines.

b. Financial hardship determinations are based upon a review of household income, assets, and liabilities in relation to current Federal Poverty Income Guidelines. As part of the process, we generally evaluate income levels, net worth, employment status, other financial obligations, the amount and frequency of healthcare bills, and other circumstances. *Insured patients who choose not to have their claim filed with their insurance company are not eligible for our financial hardship assistance program.*

c. Upon verification of a patient's financial hardship, the practice uses the below structure to determine the level of discount.

When Family Income is:	**Discount off Charges**
Over 3.00 x poverty level	No discount
2.5 – 3.00 x poverty level	40%
2.0 – 2.49 x poverty level	55%
1.5 – 1.99 x poverty level	70%
1.0 – 1.49 x poverty level	85%
0.0 – 0.99 x poverty level	100%

e. The determination of financial hardship is applicable to the current episode of care. To waive or reduce future payments, the patient must again prove financial hardship. The patient and the Business Office representative shall sign a statement detailing that the practice has reviewed proof of financial hardship, and what bills are being reduced or waived.

7. <u>Applying for Patient Financial Assistance</u>

a. The patient or responsible party must complete the attached Patient Assistance Program Application, and sign the form at the bottom of Page 2.

b. Submit the completed worksheet and any supporting documentation (e.g., W-2s, Federal tax return, pay stubs, bank statements, proof of income, unemployment forms, other hardship approvals, etc.) to our Business Office for review.

c. We will review your package upon receipt and contact you if additional information is required. Applications will not be approved for patient financial assistance when required forms are incomplete or necessary documentation is missing.

d. We will contact you regarding your application, generally within 5 business days after we receive your complete application and all required attachments. The representative will inform you of our decision regarding your request for patient financial assistance and, if applicable, the level of discount for your outstanding medical bill with Cardiovascular Associates.

PATIENT ASSISTANCE PROGRAM APPLICATION

Cardiovascular Associates of Charlottesville

PATIENT INFORMATION		
Patient Name	Date of Birth	Social Security Number
Home Address (e.g., P.O. Box or Street, City, State, Zip)		
Home Phone	Work Phone	Cell Phone
Number of Persons Living in Household (Including patient): _____ Adults _____ Children		
Date(s) of Service		
Name of Person Completing Form (if not pt.)	Relationship to Patient	Telephone

EMPLOYMENT INFORMATION		
	Patient / Guarantor #1	**Spouse / Guarantor #2**
	Employed ☐ Unemployed ☐ Start Date: _____ Retired ☐ Start Date: _____	Employed ☐ Unemployed ☐ Start Date: _____ Retired ☐ Start Date: _____
Employer #1 (Incl. name & address)		
Employer #2 (Incl. name & address)		
Employer #3 (Incl. name & address)		

INCOME	Patient/Guarantor #1	Spouse/Guarantor #2
1. Gross salaries, wages before taxes		
2. Business Income		
3. Rental Income		
4. Investment Income		
5. Income from Estates/Trusts		
6. Alimony Income		
7. Child Support		
8. Social Security		
9. Aid to Dependent Children		
10. Public Assistance Income		
11. SSI/Disability		
12. Pension		
13. Other Income (list amount/source)		
14. Other Income (list amount/source)		
TOTAL INCOME ALL SOURCES		

ASSETS	Patient/Guarantor #1	Spouse/Guarantor #2
1. Cash on hand		
2. Checking Account(s) balance		
3. Savings Account(s) balance		
4. Mutual Funds current value		
5. Stocks current value		
6. Bond(s) current value		
7. Home - assessed value		
8. Rental property assessed value		
9. Business property assessed value		
10. Auto #1 Value - Make, Model, Yr		
11. Auto #2 Value - Make, Model, Yr		
12. Auto #3 Value - Make, Model, Yr		
13. Recreational Vehicle(s) est. value		
14. Boat(s) est. value		
15. Cash value of life insurance		
16. Cash value of pension		
TOTAL ASSETS		

EXPENSES	Patient/Guarantor #1	Spouse/Guarantor #2
1. Rent/House Payment		
2. Car/Truck Payments		
3. Car Insurance		
4. Utilities (electric/phone/gas/water)		
5. Food/clothing		
6. Credit card payments		
7. Loan payments (Bank, school)		
8. Health/Dental Insurance		
9. Child care		
10. Child Support Payments		
11. Life Insurance		
12. Property Insurance		
13. Property Tax		
14. Medical Fees (Dr, Rx, Hospital)		
15. Other		
16. Other		
TOTAL EXPENSES		

PATIENT ACKNOWLEDGEMENT & SIGNATURE

I acknowledge that the information given herein is true and correct. I authorize Cardiovascular Associates of Charlottesville to verify any information contained in this document for the sole purpose of assessing financial need.

Signature of Patient or Legal Representative	Date	Relationship to Patient: ☐ Self ☐ Other _____

NOTE: Additional documentation requirements are listed on the next page.

DOCUMENTATION REQUIREMENTS

Appropriate documentation of financial hardship requires the following:

1. Income and Assets Documentation, including:
   - W-2 withholding statements or unemployment check stubs for the past 90 days
   - Pay check stubs for the past 90 days for all persons employed in the home
   - Income tax return (most recent signed 1040 and/or W-2)
   - Proof of all other income received in the past 90 days
   - Application Forms from Medicaid or other State-funded medical assistance program
   - Forms from employers or welfare agencies.
2. Evidence of additional circumstances that indicate financial hardship, such as:
   - Proof of all outstanding debts or bills (copies of bills, statements; late notices, etc.)
   - Proof of bankruptcy settlement (if applicable)
   - Catastrophic situations (death or disability in family, divorce) or other documentation which demonstrates the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses.
3. Please describe other circumstances supporting your financial hardship:

_____

_____

_____

_____

CARDIOVASCULAR ASSOCIATES USE ONLY

Review Comments

Financial Hardship Verified? ☐ **Yes** ☐ **No**

If Yes, percent reduction of charges: _____ Other: _____

Reviewer's Name	Signature	Date