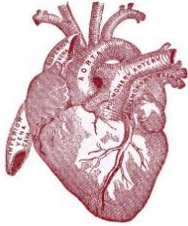


CARDINAL HEART & VASCULAR, PLLC

HORNER BLVD
RD, NC 27332

4380 FAYETTEVILLE RD
LUMBERTON, NC 28358

PHONE: 919-718-0102
FAX: 919-718-1142

SURIYA JAYAWARDENA MD, FACC, FASCAI

FINANCIAL POLICIES

Thank you for choosing Cardinal Heart & Vascular, PLLC for your cardiology needs. We are committed to treating your illness successfully. The following is a statement of our Financial Policy.

WE ACCEPT: Cash, Checks, and All Major Credit Cards

Regarding Insurance

Your Insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do not accept assignment of benefits and your insurance company has not paid your account in full within 30 days, the balance may automatically become your responsibility. We are participating providers with all major insurance plans, **ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED.** Cardinal Heart & Vascular, PLLC will file your insurance claim. **HOWEVER**, it is the patient's responsibility to provide our office with current insurance information and signed authorization giving us consent to file your insurance claim.

Our practice is committed to providing the best medical treatment to our patients and we charge what is usual and customary for our area.

Self-Pay

We see patients that do not have any insurance as well. However, we require the patient to sign a truth and lending form. This form is an agreement between the patient and our office to establish a payment plan for the services rendered. We require a portion of your bill to be paid at the time the agreement is signed. **We would like our patients to pay $100 up front for the 1st visit, however we can work with you.**

Missed Appointments

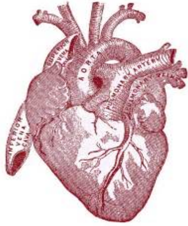
If you need to cancel your appointment for any reason you must give our office a 24-hour notice that you are cancelling for regular office visits or you will be charged $25. If you are cancelling for a Stress Test you must give a 48 hour notice due to medication being ordered specifically for you or you will be charged a fee of $150. **INSURANCE COMPANIES WILL NOT COVER THESE CHARGES, SO IT IS EXTREMELY IMPORTANT TO KEEP YOUR SCHEDULED APPOINTMENTS.**

Returned Checks

If your check is returned to us for Non-Sufficient Funds or Closed Accounts, we will charge you the fee that our bank charges us. This is a $60.00 fee on top of the amount of your check. Keep in mind that even if you have health insurance the fee for service is ultimately the patient's responsibility.

I have read and agree to this Financial Policy:

X____ DATE: _________________________



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Patients Last name: ___________________ First Name: ___________________________ MI: _____________

Address: ____ Apt: _____________

City: __________________________________ State: ____________________ Zip Code: _________________

Home Phone: ________________________ Cell Phone: _______________ Work Phone: ________________

Birth Date: ______________________SSN: ________________Age: ______________Sex: ________________

Marital Status: ____________________________ Driver's License#: _____________________State: ______

Occupation: ____ Employer: ____________________________

Employers Address: ____ E-Mail: _________________________

City: ________________________________ State: ___________________________ Zip: _________________

Spouse's Name: Spouse SSN: ____________________________ Spouse's Birth Date: ___________________

Spouse's occupation:___________________________ Employer:____________________________________

Spouse's Employer Address:____

City: _____________________________________ State: ________________________ Zip: _______________

Emergency Contact: _______________________________Relationship to patient: ____________________

Emergency Contact Phone number: _______________________Name of Referring MD: _______________

Name of Family Doctor: ________________________________Phone number: _______________________

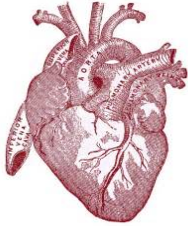
Do you have Insurance? Yes / No, If No how do you plan to pay? ___________________________________

Primary Insurance Company Name: _________________Policy Holder Name: _________________________

Policy ID# __________________Group#___________________ Effective Date: ________________________

Secondary Insurance Company Name: _________________________Policy Holder Name: _____________

Policy ID#: ______________________ Group # ______________________Effective Date: _______________



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HIPPA PRIVACY- PRACTICES FOR PROTECTED HEALTH INFORMATION

I, ____ (patient/ parent/legal guardian), understand that as part of my health care, Cardinal Heart & Vascular, PLLC originates and maintains paper and/or electronic records, describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I have the following rights and privileges:

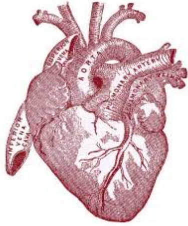
- The right to review the Notice of Privacy Practices (45 CFR 164.520) prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Cardinal Heart & Vascular, PLLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section164.520 of the Code of Federal Regulations.

I further understand that Cardinal Heart & Vascular, PLLC reserves the right to change their notice and practices and prior implementation, in accordance with Section164.520 of the Code of Federal Regulations. Should Cardinal Heart & Vascular, PLLC change their notice, they will post the revised copy in the reception area at the office and provide a copy to me at my request. I understand and agree that Cardinal Heart & Vascular, PLLC may contact me at my home or work number provided concerning appointments and other relevant medical information.

I wish to have the following restrictions added to the use or disclosure of my health information and/or alternate communications:

____
____



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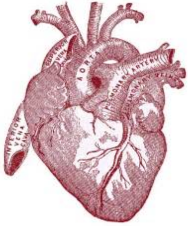
I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via electronics, fax, telephone or mail.

Please Check One

- I fully understand and accept the terms of this consent
- I fully understand and decline the terms of this consent

Patient/Parent/Legal Guardian Signature: ____ Date: _____________



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SURIYA JAYAWARDENA MD, FACC, FASCAI

Patient Name: ________________________________ DOB: ____________________ SSN#_________________________

Medical History

Reason for Visit today: ____

Allergies

Medication: ____

Food: ____

Iodine(contrast) Dye, Seafood, Shellfish, Etc.: ____

Medications (please list dosage and frequency, and include over the counter medicine)

1. ___________________________	6. ___________________________	11. ___________________________
2. ___________________________	7. ___________________________	12. ___________________________
3. ___________________________	8. ___________________________	13. ___________________________
4. ___________________________	9. ___________________________	14. ___________________________
5. ___________________________	10. ___________________________	15. ___________________________

Do you have any of the following:

○ Heart disease	○ Retinal hemorrhage	○ Dialysis
○ Chest pain	○ Cataracts	○ Urinary bladder problems
○ Angina	○ Asthma	○ Prostate enlargement
○ Heart attack	○ Emphysema	○ Prostate cancer
○ Stents	○ Bronchitis	○ Arthritis
○ Bypass	○ Lung cancer	○ Skin problems
○ Murmur	○ Hiatus hernia	○ Epilepsy/seizures
○ Valve problems	○ Peptic ulcer	○ Brain tumor
○ Valve surgeries	○ Liver problem	○ Depression
○ Congestive heart failure	○ Jaundice	○ Anxiety
○ Irregular heart beats	○ Hepatitis	○ Bleeding problems
○ Pacemaker/defibrillator	○ Diet pills	○ Anemia
○ Fainting	○ Colon cancer	○ Blood transfusions
○ High blood pressure	○ Colitis	○ Glaucoma
○ Cholesterol	○ Diverticulitis	○ Eye problems
○ Stroke	○ Hemorrhoids	○ Cancer:
○ Diabetes	○ Kidney stones	○ Other medical problems:
○ Tobacco use	○ Kidney failure	________________________
○ Carotid Surgery		________________________

Previous surgeries or Hospitalizations:

____

____

Personal Habits:

Tobacco Use: Cigarettes: ______/Day Cigars: _______/Day Chewing/Dip: _______/Day

Alcohol Use: Y/N Type:________________________Amount: _____________/Day or ______________/week

Caffeine: __________/day Chocolate/Candy: _____________/Day Recreational drugs: __________

Family History:

____

____

____

EMAIL US AT: CARDINAL2609@GMAIL.COM