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CARDIOLOGISTS OF LUBBOCK

Experience you can trust. Compassion you deserve.

Leading-edge care with a personal touch:

- Interventional cardiology
- Electrocardiography
- Nuclear cardiology
- Echocardiography
- Peripheral vascular testing
- Angiography
- Cardiac CTA
- Balloon angioplasty & stents
- Holter monitoring
- Stress testing
- Diagnostic catheterization
- Vascular ultrasound
- Anticoagulation testing
- Pacemaker implantation
& follow-up
- Preventive cardiology – avoiding
heart attacks
- Lifestyle & nutrition counseling

With all the convenience you deserve:

- Flexible appointments,
including same-day
- 24-hour emergency care
- Friendly, caring staff
- State-of-the-art facility
- Most insurance accepted & filed
- Visa & MasterCard welcome

4802 N. Loop 289
Lubbock, TX 79416
Phone: (806) 788-0040
Fax: (806) 788-0015

Toll-free: 1-800-915-0040
www.CardiologistsOfLubbock.com

Welcome to our office and **THANK YOU** for choosing Cardiologists of Lubbock for your cardiology needs. We do want to let you know that Dr. Joseph Rizzo has recently retired from Cardiologists of Lubbock in September 2020. Our other Interventional Cardiologists are honored to be providing you world class cardiovascular care you.

If your cardiologist determines that you need to undergo further cardiac testing, the clinical staff and/or a Patient Account Representative will schedule this. Your insurance, the type of procedure being performed, your schedule and your physician's schedule will all be taken into consideration when choosing a location for your procedure.

Hospital procedures are performed at Lubbock Heart Hospital and Covenant Medical Center. Most outpatient testing (nuclear, echo/PV, CT) are performed at Cardiologists of Lubbock.


After your procedure is scheduled, you will meet with one of our Patient Account Representatives. They will explain:

- The cost of your procedure
- The amount your insurance will cover
- The amount you are responsible for paying

It is our policy to collect the patient portion of your procedure **prior** to the procedure. The patient portion can include your deductible and any co-insurance amounts not covered by your policy. You have the option of paying with cash, personal check, credit card or money order.

NO SHOW POLICY: Please note that you will be charged at \$25.00 no show fee if you fail to give us a 24-hour notice of your intent to cancel your doctor appointment. In addition, you will also be charged a separate \$50.00 no show fee for failure to give us a 24-hour notice of your intent to cancel your testing (nuclear, echo/PV, CT, etc) appointment(s).

Repeated missed appointment may result in dismissal from our practice.

A member of Texas Physicians Group
Affiliate of  Lubbock Heart & Surgical Hospital



FINANCIAL POLICY

We want to thank you for choosing Cardiologists of Lubbock for your cardiology services. We have developed this financial policy to clarify our billing practices and to avoid any confusion in the future.

For your convenience, we accept payment by cash, check, VISA, MasterCard, Discover, or debit card.

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit.

All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud.

Medicare Patients: All of our physicians, physician's assistants, and nurse practitioners are Medicare providers, and we will submit your bill to Medicare for you. **However, you are responsible for payment of your Medicare deductible each year.** If you have secondary insurance, we will submit your claim to your secondary insurance as a courtesy to you, if you provide us with accurate information. If we do not receive payment from your secondary payor within 60 days after the Medicare payment has been received, it will be your responsibility to make payment at that time. **For patients without secondary insurance, you will be required to pay the 100% of your coinsurance at the time the service is rendered.**

Patients with Managed Care/PPO Plans: You will be asked to pay any deductible or copay due per your plan prior to the service being rendered. It will not be waived as long as the physician has rendered the service.

Patients with No Insurance: You will be asked to pay for each visit at the time of service.

Broken appointments: Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24-hour notice of cancellation to avoid a cancellation fee.

Form completion: All forms requiring medical review and physician signature, including, but not limited to, FMLA, disability, etc. are subject to an administrative fee of \$25.00. These charges are not covered by insurance and must be paid before completion of the form.

Lastly, it is the patients' responsibility to notify the front desk of any changes in insurance coverage before the service is rendered. Any charges denied because of termination of coverage when we have not been informed, or because of a pre-existing condition, will be billed directly to the patient upon receipt of denial from the insurance company.

Nonpayment: If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. **Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice.** If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, your physician will treat you on an emergency basis only.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date

**Authorization for Payment and/or Release of Information to
Private or Supplemental Group Insurance**

Patient Name

Chart Number

Address

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly
To the undersigned physician or physicians of the surgical and/or medical benefits, if
any, otherwise payable to me for his services as described below, but not to exceed the
reasonable and customary charge for those services.

Signed (insured person, parent or legal guardian)

Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned
physician to release any information acquired in the course of my examination or
treatment.

Signed (insured person, parent or legal guardian)

Date

MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my
behalf to Texas Physicians Group/Lubbock Heart Hospital for any services furnished me
by that Professional Association. I authorize any holder of medical information about
me to release to the Health Care Financing Administration and its agents for information
needed to determine these benefits or the benefits payable for related services.

Signature (only if you have Medicare)

Date

NOTICE OF FINANCIAL INTEREST

At times, hospital services are required for our patients. Although we have a financial interest in the Lubbock Heart Hospital, we are pleased to care for you at the hospital of your choice. These choices include the following institutions:

Lubbock Heart Hospital
Covenant Medical Center
Covenant Medical Center – Lakeside

Printed Name

Date

Signature

NOTICE

Patient Billing
for
Texas Physicians Group, dba Cardiologists of Lubbock
(Affiliate of Lubbock Heart and Surgical Hospital)

Lubbock Heart and Surgical Hospital is the owner of the Ancillary Service Center at Cardiologists of Lubbock.

This means that patients may potentially receive notice of two separate filings of insurance claims for services rendered by the primary care physicians and the hospital.

1. One claim will represent **physician** fees; and
2. An additional claim will be for **hospital** outpatient EKGs, lab tests and/or radiology exams.

Depending on your insurance coverage, patients may experience:

1. One coinsurance and deductible for **physician** services; and
2. An additional coinsurance and deductible for **hospital** ancillary services.

Dr: _____

Chart #: _____

**CARDIOLOGISTS OF LUBBOCK
PATIENT INFORMATION SHEET**

Date: _____

Name: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Social Security #: _____ E-Mail Address: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Employer: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Spouse or Parent Information

Name: _____ Relation: _____

Employer: _____ Home Phone #: _____

Work Phone #: _____

Emergency Notification Outside of Home

Name: _____ Relation: _____

Employer: _____ Home Phone #: _____

Work Phone #: _____

INSURANCE INFORMATION

Primary - Insurance company: _____

Insured's Name: _____ **Insured's DOB:** _____

Secondary - Insurance company: _____

Insured's Name: _____ **Insured's DOB:** _____

Revised 12/01/16

Chart # _____

**CARDIOLOGISTS OF LUBBOCK (COL)
LUBBOCK HEART HOSPITAL (LHH)
Acknowledgement of Receipt of Notice of Privacy Practices**

I, _____, acknowledge that I have received a copy of COL/LHH Notice of Privacy Practices.

Patient Signature

Date

Patient Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to patient

FOR COL USE ONLY

CO/LHH made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.)

COL Representative

Date

*A Member of Texas Physicians Group
(Affiliate of Lubbock Heart and Surgical Hospital)*

TEXAS PHYSICIANS GROUP (TPG)
LUBBOCK HEART HOSPITAL (LHH)

Chart #: _____

Consent for Special Disclosure of Protected Health Information

Please check Yes or No for the following:

I, _____, consent to TPG/LHH employees identifying themselves and leaving messages on my answering machine (if I have one), for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call TPG/LHH.

Yes No

I consent to TPG/LHH employees identifying themselves and leaving a message with those who answer my home phone for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to contact TPG/LHH.

Yes No

I consent to TPG/LHH employees contacting me at work, if applicable, for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call TPG/LHH

Yes No

I consent to TPG/LHH employees disclosing my private health information such as test results and billing information with a designated family member or personal representative.

Yes No

* If yes, please designate the person(s) to whom such information may be disclosed:

Name: _____

Address: _____

Phone number(s): _____

Relationship: _____

Name: _____

Address: _____

Phone number(s): _____

Relationship: _____

(If more than two people, please list additional names on separate page)

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Name: _____

Chart #: _____

Additional person(s) to whom private healthcare information may be disclosed:

Name: _____

Address: _____

Phone number(s): _____

Relationship: _____

Name: _____

Address: _____

Phone number(s): _____

Relationship: _____

Name: _____

Address: _____

Phone number(s): _____

Relationship: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make a request, in writing, to the Privacy Officer. We have up to 30 days to make the Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal law-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to a Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item

request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.lubbockheart.com. To obtain a paper copy of this notice, contact the Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

If you have any questions about this notice, please see contact information as follows:

Contact Person
Name: Christl Rister
Title: Privacy Officer
Address: 4810 IL Loop 289
Phone Number: 806-687-7777

Independent Contractors
Lubbock Heart & Surgical Hospital and the physicians who practice here are independent contractors and do not hereby assume any liability for the services or conduct of the other.

Effective Date: The effective date of this Notice is 4/14/2003; revised July 28, 2013; March 13, 2018.



**Lubbock Heart
& Surgical
HOSPITAL**

**NorthStar Surgical Center | Texas Physicians Group |
Cardiologists of Lubbock**

HIPAA Notice of Privacy Practices