HEART & VASCULAR CENTER
of
WATAUGA MEDICAL CENTER

Patient Name_____
Date of Birth_____
MRUN Number_____
Please Fill in or Affix a Patient Label

Explanation of Self-Pay Financial Plan

It is our desire at Heart and Vascular Center to provide you with the needed healthcare services and to alleviate as much of the financial concerns as possible. To assist you, we offer a 25% discount off the services provided if you do not have insurance. In addition, our billing department can help you set up no interest payment plan options or help you apply for the Financial Assistance Program.

I. In the event the patient or guarantor cannot, upon registration of the patient to the facility, produce evidence that a third party including but not limited to government agency(s), and/or insurance is legally responsible for payment of the patient's account, the charges for the goods and/or services will become the sole responsibility of the patient or guarantor.

II. A twenty-five percent (25%) discount will be applied to all accounts where charges for medically necessary services are the sole responsibility of the patient or guarantor.

III. In the event a payment source other than the patient or guarantor is identified, the twenty-five percent (25%) discount will be reversed and added to the remaining balance on the account.

IV. The discount will not apply to any patient accounts where a third party, including but not limited to government agencies or insurance, has been identified as a primary payer. Therefore the discount will not be applied to deductibles, co-pays, or coinsurances.

V. We request a $50.00 down payment at the time of service from self-pay patients and co-insurance or co-pays from insured. This amount will be applied to your final bill which you will receive in the mail.

VI. You may be eligible for our Financial Assistance Program. If you would like more information on this application process please call (828) 262-4110. Our staff can also provide you with an application and make a referral at your request.

VII. You may request to be set up on a payment plan. To do so, contact our ARHS Billing Dept. at (828) 262-4111.

By signing below, you acknowledge understanding of our self-pay plan and assume responsibility for the final bill. You are aware you will receive a final bill for all services received today. Your final statement will reflect a 25% discount and any down payments made on the date of service.

_____ _____ _____
Patient/Guardian Signature Date Time

_____
(Print Name of Guardian and Relationship of Guardian to Patient)

_____ _____ _____
Witness Date Time

Effective Date: Not Set
Revised Date: 08/03/2020