



# Lafayette Heart and Vascular Clinic

433 La Neuville Rd, Youngsville, LA 70592 | Phone: (337) 516-2800 | Fax: (337) 516-2801 | Email: patient@lafayetteheart.com

## Self-Pay and Out-of-Network Patient Payment Agreement

### Financial Responsibility

I, the undersigned patient or authorized representative, acknowledge and agree to be financially responsible for all charges related to services and/or investigations provided by Lafayette Heart and Vascular Clinic physicians and/or providers, including those rendered at affiliated facilities including hospitals and/or outpatient catheterization labs, and/or ambulatory surgical centers.

### Payment Terms

I understand that all charges are due in full on the day of service. These charges pertain solely to professional services provided by Lafayette Heart and Vascular Clinic physicians/providers, including those rendered at affiliated facilities.

### Exclusions

I acknowledge that services provided by external entities, including but not limited to laboratory tests, X-rays, CT scans, MRIs, hospital procedures, and certain stress tests, are not included in this fee and will be billed separately by the respective physicians/providers and/or facilities.

### Documentation and Billing

I understand that I am entitled to personally receive, one time, free of charge, copies of clinic notes and investigative reports that was performed at the clinic related to these services. We are not responsible for providing medical records to your insurance or communicate with your insurance company. Upon request, you will be provided with an invoice and receipt corresponding to the services rendered.

### Insurance and Reimbursement

I acknowledge that my medical insurance is a contract between myself and the insurance company. Any determinations made by the insurance company are solely between myself and the insurer. I understand that my insurance may not reimburse me for any amount paid for these services, and I accept full responsibility for seeking reimbursement from my insurance company, if applicable.

**Important:** The payment for the services I will receive may be significantly higher than what I would incur through in-network care. My insurance provider may not apply the payment I am making to my contracted deductibles, co-insurance, or out-of-pocket maximums. It is my responsibility to confirm with my insurance provider the extent of my coverage for these services.

### Coding and Reimbursement Disclaimer

I understand that the billing codes on the invoice, receipt, and/or CMS-1500 form represent the clinic's/physician's best efforts but do not guarantee accuracy or reimbursement from my insurance company. I acknowledge that my insurance company may modify these codes according to their policies or CMS guidelines, potentially affecting reimbursement. I agree not to hold the clinic or physician responsible or liable for such changes or their impact on reimbursement.

### Acknowledgment and Consent

By signing below, I certify that I have read, understood, and agree to the terms and conditions of this Self-Pay and Out-of-Network Patient Payment Agreement. I acknowledge receipt of a copy of this agreement and possible charges. I have reviewed and discussed the charges I will incur and agree to pay in full prior to services being provided. All my questions have been satisfactorily answered.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Estimated Charges: \_\_\_\_\_

Patient/Representative Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

If signed by representative, indicate relationship to patient:  Spouse  Parent/Guardian  POA  Other: \_\_\_\_\_