



Office Locations and Contact Information

McKinney Medical Village
7300 Eldorado Pkwy, suite 230
McKinney, TX 75070

Medical City Dallas, Professional Building C
7777 Forest Lane, suite C608
Dallas, TX 75230

Phone (972) 372-4505 / **Fax** (855) 867-7973 **Email** info@hrsmedical.com

Office Hours

Monday-Friday 8:00 am – 5:00 pm

Phone Hours

Monday-Friday 8:30am - 4:00 pm

Below you will find our current office policies. Please read each carefully, initial, and sign. We are privileged to be a part of your medical care team. Our goal is that this information will be helpful to you when accessing our office and making decisions about your health.

Appointments

All office visits are scheduled by appointment only. We offer both **telemedicine** and **in-person** appointments. For telemedicine visits, please ensure you have an updated medication list and recent blood pressure readings available.

We strive to be on time, but due to the nature of our practice, occasional delays may occur. We appreciate your understanding, as our physician may be attending to another patient. If you are more than **15 minutes late** for your appointment, we will need to reschedule.

Emergencies may also impact scheduling. If we need to adjust your appointment, we will make every effort to find a new time that works for you. Should you need to cancel or reschedule, please notify us at least **24 hours in advance**.

No-Show/Cancellation Fee:

- **\$75.00** fee for missed appointments or cancellations/rescheduling with less than 24 hours' notice.
- This fee is **not** covered by insurance and is the patient's responsibility.

Referrals

If your insurance plan requires a referral, it is your responsibility to obtain this referral prior to your appointment. Failure to provide the required referral will necessitate rescheduling your appointment.

Patient Dismissal

In order to ensure timely and effective care for all our patients, we reserve the right to dismiss a patient from our practice under certain circumstances, including but not limited to:

- Three or more missed appointments without prior notice.
- Failure to follow recommended treatment plans.
- Use of abusive, disrespectful language towards staff.
- Threats or acts of violence towards staff or other patients.

If you are dismissed from our practice, we will provide you with a list of alternative qualified specialists in the Dallas-Fort Worth area.

Surgery/Procedure Cancellation Policy

Due to the complexity of scheduling procedures, we require advanced notice for cancellations or rescheduling:

- **\$250.00** fee for cancellations within **1 week** of the scheduled procedure.
- **\$500.00** fee for cancellations within **72 hours** of the scheduled procedure.
- **\$750.00** fee for cancellations within **24 hours** of the scheduled procedure.

These fees are **not** billable to your insurance company and will be the patient's responsibility.

Telephone Calls and Medication Refills

Please contact us during normal business hours for non-urgent matters or prescription refills. Calls made after **3:00 PM** may not be returned until the next business day. Kindly allow **2-3 business days** for prescription requests to be processed.

To avoid delays, please refrain from calling multiple lines or leaving multiple messages regarding the same issue.

After Hours Communication

Our after-hours phone line is the same number as our main office. If you require non-urgent care after hours, you may be charged a **\$25.00** fee per call, at the discretion of the on-call physician. This fee is **not** billable to your insurance and will be your responsibility.

Medical Records/FMLA/Disability

All requests for medical records, including remote device transmissions, require a **written release of information**. Please allow **up to 15 business days** for processing. A minimum **\$25.00** fee will be applied for the completion of any forms, such as for disability, medical leave, or Family and Medical Leave Act (FMLA). This fee is **not** billable to your insurance.

_____ FMLA & Short-Term Disability

There is a minimum **\$25.00** fee for completing FMLA or short-term disability forms. Depending on the complexity of the request, additional fees may apply. Please note that we only grant short-term disability for patients undergoing surgery or procedures. For other types of leave or accommodations, please contact your primary care provider.

_____ Handicap Placards

Please be aware that we do not complete forms for handicap placards. Kindly consult your primary care provider for assistance with this request.

I have read and understand the office policies of Heart Rhythm Specialists, PLLC. I acknowledge that it is my responsibility to comply with these policies as outlined above. I understand that failure to do so may result in the need to reschedule my appointments, or in some cases, dismissal from the practice.

Signature of patient or personal representative: _____

Printed name of patient or personal representative: _____

Relationship to patient: _____ Date: _____

Financial Policies

Insurance and Network Status

I understand that Heart Rhythm Specialists participates with most insurance plans; however, it is my responsibility to confirm that the provider is in-network with my specific health insurance plan. I agree to contact my insurance company directly for any questions regarding my coverage and benefits.

Proof of Insurance

I agree to bring my up-to-date insurance card and a valid driver's license with me to each office visit. If my insurance changes, I will notify the office before my next appointment to update my information, ensuring accurate billing and maximizing my benefits.

Co-payments, Co-insurance, and Deductibles

I understand that all co-payments, co-insurance, and deductibles are due at the time of service. I acknowledge that failure to collect these amounts may result in my account being referred to collections. Payments can be made via cash, check, or credit card (Visa, MasterCard, American Express, Discover).

Claim Submission and Assignment of Benefits

I authorize Heart Rhythm Specialists to submit insurance claims on my behalf and assign all insurance benefits directly to the practice. I understand that I am financially responsible for any balance not covered by my insurance, including but not limited to any deductibles, co-insurance, or amounts denied by my insurance carrier. I agree to promptly pay any outstanding amounts not covered by insurance, including any denied claims, directly to Heart Rhythm Specialists.

Non-covered Services

I understand that some services may not be covered by my insurance plan or may be deemed not medically necessary. While the office will assist with any necessary appeals, I accept responsibility for payment for any non-covered services.

Nonpayment

I acknowledge that there is a \$75.00 fee for returned checks. In the event of nonpayment, I understand that my account may be referred to a collection agency if payment is not received in a timely manner.

By signing below, I confirm that I have read, understand, and agree to the financial policies outlined above and acknowledge my responsibilities as a patient of Heart Rhythm Specialists, PLLC.

Signature of patient or personal representative: _____

Printed name of patient or personal representative: _____

Relationship to patient: _____ Date: _____