# Financial Policy

Total Vein Care is dedicated to providing you the best care possible. If you have health insurance, we are committed to helping you receive your maximum allowable benefits. Therefore:

- **As a courtesy**, we will attempt to verify your benefits with your insurance company via phone, and when necessary, we will obtain pre-authorization or pre-determination of benefits prior to your procedure. ***You share in the responsibility by knowing what your plan covers and for verifying your benefits with your insurance company.*** We will do our best to obtain a financial estimate regarding your responsibility of procedure charges, and this information is based on the verbal information obtained from your insurance company. Because these are ***estimates only***, the final cost for services is not fully known until the claim has been adjudicated by your insurance company. The estimated charges that are your responsibility pursuant to your insurance policy are due the ***day of your procedure***. We accept cash, checks, MasterCard, Visa, Discover and American Express. We also accept Care Credit.
- I request that payment of authorized insurance and Medicare benefits be made payable to Total Vein Care on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office. I understand and agree to pay a returned check charge of $25.00 for each check that is returned for any reason. In case of default, I agree to pay any and all costs of collecting this account including, but not limited to, attorney fees and court costs.
- Please note the estimate we obtain is for your ***procedure only***. It does **NOT** include **ANY** charges that may occur from the New Patient visit or Post-Op appointments. Again, we have no control over how the insurance companies pay or apply charges.
- TVC will file an insurance claim with your insurance company and an explanation of benefits will be sent to you and TVC. Any overpayment by you will be refunded and any amount owed by you will be due at this time. We emphasize our relationship is with you and not your insurance company. In the event that your insurance carrier denies payments or pays less than expected, you are responsible for any balance on your account. The insurance company's decisions and payment amounts are not within our control; however, we are happy to assist you in the insurance appeal process. If it becomes necessary to collect your unpaid balance using a collection agency, you will also be responsible for any charges incurred as a result of the collection activity (usually 20-50% of unpaid amount) as well as any legal or court fees incurred.
- Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for full amount due until the account is satisfied. I agree that if the insurance company denies benefits for some reason, I am responsible for the full amount owed for services provided.
- I authorize the holder of medical information about me to release any and all information to Centers for Medicare or Tricare Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Total Vein Care to release information concerning any diagnosis and treatment to my primary care or referring physician after each visit.
- Failure to cancel your office visit within 24 hours of your scheduled appointment will result in a $50 charge. Failure to cancel your surgery within 48 hours of your scheduled surgery will result in a $300 charge. Any cancellation fees are due by you and are not billable to your insurance company.

**AGREEMENT**

I, (print name) ________________________________________understand that I am financially responsible for services rendered and any balance after insurance processing. I have read and understand the terms and conditions of my financial obligation and agree to honor the office policies outlined above.

Patient Signature: ___________________________________________Date:___________________

Initials:________ (The parties to this agreement acknowledge that signing their initials in place of a signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used.