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PATIENT FINANCIAL POLICY

Advanced Vein & Vascular's physicians and staff are committed to providing you with the best possible care. We will be happy to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. **I**f your plan **requires** a co-pay, deductible or coinsurance, we will collect these at time of service. If you are not prepared for this, a billing fee of $10.00 will appear on your billing statement. In the case of a minor, the patient's accompanying parent/guardian is responsible for payment. For self-pay surgical procedures in excess of $1,000, we request a cashier's/bank check.

Please provide our staff with the required Insurance information that enables us to bill your carrier. In most cases, even participating insurance plans will have a "patient responsibility" balance. **It is the patient's responsibility to know his or her limitations, exclusions, deductibles, co-insurances and co-pays that will apply under their specific insurance plan**. We will give you the **best estimate** possible with the tools we have. **(Please Initial)** _________

WE ACCEPT CASH, CHECKS, VISA, DISCOVER, & MASTERCARD Due to high fees charged to merchants (that would be AVVC) by credit card companies (AMEX, Visa, MasterCard) especially for costly "reward cards", and due to declining reimbursements, we in turn need to pass on those fees. There will be a charge for the use of credit cards._________

NON-PARTICIPATING INSURANCE PLANS

We are out of network with United Healthcare and Devon Health Services. For these plans we fall under **out of network benefits**. If you do not have out of network benefits, your carrier will not pay for our services, and we will expect payment on date of service.

MEDICARE / MEDIGAP

MEDICARE PATIENTS HAVE A 20% COPAY AND A DEDUCTIBLE OF $___________

"I request that payment of authorized Medicare and Medigap benefits be made on my behalf to Advanced Vein & Vascular Center Inc. For services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service." Some routine service's (stockings, arnica & cosmetic services) are not covered by Medicare"_________________ **(Patient Signature)**

DELINQUENT ACCOUNTS

An account is considered past due 30 days following billing unless other arrangements have been made. A finance charge of 1 ½ % will be assessed to unpaid balances over 60 days. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency. **RETURN CHECK FEE:** There will be a transaction fee of $50 for any check that is returned for insufficient funds.

MISSED APPOINTMENTS

We would appreciate your help and the courtesy of a call if you are unable to keep your scheduled appointment. We reserve the right to charge a missed appointment fee for each appointment that is not canceled in a timely manner. Missed **Office visits** with less than 48 hour's notice will be charged $50.00. All missed **Procedures (Sclerotherapy, Vein Closure or Clarivein and Microphlebectomy)** with less than **5 days business notice** will be charged $100 as supplies prepared for your procedure are then wasted. **(Please Initial)** _______

In compliance with HIPAA Privacy Standards, Advanced Vein & Vascular Inc. will protect the confidentiality of the patient information and use it only for insurance coverage and related matters. The signature below acknowledges that the patient has been given the entity's Notice of Privacy Practices and has provided permission for use of information in obtaining coverage and payment information.

Received AVVC'S Privacy Policy Notice: ______Parent/Guarantor Signature (if minor) ___________________________

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH, READ AND UNDERSTAND THE FINANCIAL POLICY STATED ABOVE AND AGREE TO BE SUBJECT TO SAME. I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF ADVANCED VEIN &VASCULAR'S NOTICE OF PRIVACY PRACTICES.

Date: _______________ Name: (print) _____________________________ Signature: _____________________________