THE VEIN CLINIC , INC.
FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please talk to our Business Manager if you have any questions about our fees or Financial Policy.

1. All patients must complete our "Patient Registration Form" prior to seeing the doctor.
2. Full Payment is due at time of service.
3. We accept cash, checks, and Visa/Mastercard.

REGARDING INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to this contract. You are responsible for the timely payment of your account.

Our practice is contracted with a number of PPO, HMO, and Managed Care network plans. Please see the attached list of most of the major insurance plans we accept. If your insurance company is not listed, please ask the receptionist for more information.

If we accept your insurance, you must pay any co-payments and unmet deductibles at all times of service. Please be aware that some and perhaps all of the services provided may be "non-covered" services and not considered necessary under the Medicare Program and/or other medical insurance. This especially includes services for well care, such as general physicals. If not covered, you will be responsible for payment of these services.

If the reason for your visit is a work-related injury or an accident, please notify the receptionist.

DIAGNOSTIC STUDIES, X-RAY, AND OTHER ANCILLARY SERVICES

If any diagnostic studies such as laboratory tests, x-rays and other ancillary services are required to complete your care, please be aware that these charges are billed directly to you from the facility rendering the care. This is separate from the office charges and may constitute an additional expense for which our office is not responsible.

Thank you for understanding and agreeing to our Financial Policy. Please let us know if you have any questions or concerns.

I hereby authorize The Vein Clinic, Inc. to furnish information to the insurance carriers concerning my illness and treatments. I also authorize to The Vein Clinic, Inc. all payment for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance.

Signature of Patient or Responsible Party Date

Revised 1/1/2015