



Financial Policy and Patient Agreement

YOUR RESPONSIBILITY

You are financially responsible for the services we provide to you. We understand that many patients arrange for insurance companies to pay for a large portion of medical claims. However, **the patient** (or legal guardian if the patient is a minor) **is ultimately responsible for the bill if the insurance company does not pay.**

We provide two courtesies to our patients

1. We will contact your insurance carrier to request a pre-authorization/pre-determination for any planned treatments (excluding treatment of spider veins and any cosmetic procedures), if required by your insurer. It is important to understand that even if the insurance company provides authorization for treatment, it does not guarantee that they will pay once services have been performed.

FOR THIS REASON, WE STRONGLY RECOMMEND YOU CONTACT YOUR INSURANCE COMPANY DIRECTLY (1) TO CONFIRM WHAT DEGREE OF PAYMENT YOU CAN EXPECT FROM THEM BASED ON YOUR INDIVIDUAL PLAN, AND (2) TO CONFIRM THAT ANY PLANNED PROCEDURES ARE INCLUDED IN THE PLAN YOU CHOSE.

2. We will file a claim to your primary and secondary insurance plans.

We do expect payment of co-payments (e.g. Coinsurance, Deductible, non-covered services, etc.) at the time services are rendered and these payments will be collected at the time of check-in. If you are unsure of your financial responsibility, please contact your insurance company, in advance, to obtain this information. Should you need to make payment arrangement prior to your scheduled appointment, please call 615-884-7600. Any balance remaining after insurance has paid their part of the covered portion will be due upon receipt of a statement.

MISSED APPOINTMENTS AND NO SHOWS

As a courtesy to our patients, we will call you to remind you in advance of your upcoming appointment. Our staff will contact you at the telephone numbers you

Patient/responsible parties initials: _____



have provided 24-72 hours prior to your scheduled appointment.

We make every effort to honor all time commitments and request that you extend the same courtesy to us by letting us know at least 24 hours in advance if you are unable to keep your appointment.

- A fee of **\$50.00** will be assessed to your account if 24 hour advanced notice is not given for office visits and ultrasound appointments.
- We require a **50% deposit** for sclerotherapy no later than 7 days prior to the procedure. The remaining balance is due the day of the procedure. If at least 48 hours notice is not given for a cancellation, your deposit will not be returned.
- A fee of **\$250.00** will be assessed to your account if 48 hour advanced notice is not given for Vein Procedures (Vein ablation or phlebectomy)

These fees are not covered by insurance carriers or Medicare and will be your responsibility to pay at the time of your next visit. An appropriate notice of cancellation provides us with the ability to schedule patients on our wait list. *Our goal is to open otherwise unused appointment time for other patients needing care, not to collect missed appointment fees.*

PRIOR BALANCE

Patients with a prior balance at the time services are requested will be asked to pay the prior balance in full before being seen. If the balance cannot be paid in full, then you must speak with a financial counselor to make payment arrangements prior to your appointment.

PATIENTS WITHOUT INSURANCE

We are pleased to be able to provide services to patients that do not have insurance. However, if you do not have insurance you will be expected to pay upon check-in before services will be provided.

MEDICARE PATIENTS

Siragusa Vein and Laser accepts Medicare assignment. We will also bill your secondary insurance if you provide us the proper insurance information. You are responsible for the applicable coinsurance and deductibles, and charges for non-covered services. In addition to the bill we send, you should also receive an explanation from Medicare indicating how much you owe. Patients who do not have a secondary insurance carrier, will be required to pay at the time of service his/her deductible, as well as the 20% co-insurance.

MEDICAID PATIENTS

Patient/responsible parties initials: _____



Siragusa Vein and Laser accepts Medicaid assignment. A current Medicaid card must be presented at each visit and you will be required to pay the co-pay at the time of service, if required by your plan.

PRIVATE INSURANCE PATIENTS

Siragusa Vein and Laser accepts assignment for most major insurances. You will be required to pay applicable co-payments (coinsurance and deductibles) at the time of service & you are responsible for payments for non-covered services.

WORKMAN'S COMPENSATION

Siragusa Vein and Laser gladly accepts workman's compensation. Please contact your adjuster to obtain prior approval and a listing of approved providers.

HMO PATIENTS (HealthSpring)

Siragusa Vein and Laser contracts with certain HealthSpring IPAs. You will be required to pay the applicable co-pay at the time of requested service. While we will make every effort to obtain a referral from your PCP, we ask that **you also confirm that there is an active referral from your Primary Care Physician at the time of each visit.** If you do not have a proper referral, you may be required to reschedule your appointment.

METHODS OF PAYMENT

We accept cash, check, VISA, MasterCard, Discover, and Care Credit. We do not accept post-dated checks, nor will we hold checks for any length of time.

RETURNED CHECKS There will be a **\$25.00 fee assessed** for any and all checks returned from the bank for any reason.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

INFORMATION CHANGE

Please advise us of any address, phone number or insurance changes promptly. Failure to do so may result in your insurance company not being responsible for your care, and you will subsequently be held responsible for paying out of pocket.

Patient/responsible parties initials: _____



COLLECTION PROCEDURES

Members of our billing department are always available to help you with questions and or payment arrangements. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/physician relationship. Prompt payment for services rendered is expected and failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. Once an account has been referred to an outside agency, prior balances must be resolved before being seen by a physician. *We understand that medical care can often become very expensive. If you have concerns about your ability to pay for service, we recommend that you contact us for assistance in the management of your account.*

I have read and understand the financial policy of *Siragusa Vein and Laser* and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I hereby voluntarily consent to healthcare encompassing diagnostic procedures and treatment by my physicians, his/her associates, assistants or other healthcare providers, as may be necessary in my provider's judgment. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made as to result or care. This form has been fully explained to me, and I certify that I understand its contents.

Signature of patient/responsible party: _____

Date: _____

Please print patient name: _____

Patient/responsible parties initials: _____



Revised 07/2014

Patient/responsible parties initials: _____