Vascular Health Center
Comprehensive Vascular Care

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FINANCIAL POLICY

Please bring your health insurance card and driver's license to <u>EVERY</u> appointment.

Please make sure to bring any authorization for services. This includes authorization for workers' compensation, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), etc.

- Our office will bill your health insurance unless informed otherwise.
- You are responsible for the full charge at the time the service is performed in our office, apart from **Medicare, Medicaid, HMOs and PPOs**.
- If you choose not to utilize your health insurance benefits and/or are Self-Pay, you understand you are responsible for all charges that occur at the time of service.
- **<u>Co-payment is due at the time of service</u>.** You are also responsible for your deductible, and any non-covered or non-authorized services.
- If you have an outstanding balance, payment must be made at the time of service.
- We bill your insurance for services performed by our office(s) and allow 45 days for insurance payment. If your insurance company does not pay the full amount due, you will receive a statement. The balance is your responsibility if we are unable to resolve the balance with your insurance company.
- We participate with several insurance companies. **To ensure your service(s) is covered, it is your responsibility to call your health insurance to see if we participate with your plan.**
- All unpaid balances are reviewed for possible collections after 90 days. A fee of $50 is applied to all accounts sent to collections.
- For some procedures and tests, you may also receive a bill from the hospital where the services are performed. If an anesthesiologist is present during the procedure, you will receive a statement directly from the anesthesiologist's office for service.
- **A $40 fee applies to all missed ULTRASOUND appointments if the appointment is not cancelled or rescheduled within 48 hours prior to the appointment date/time.**
- I understand payment plans are available for qualified patients.

By signing this form, I fully understand Vascular Health Center's Financial Policy and agree with the information listed above.

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

WITNESS SIGNATURE **DATE**

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