FINANCIAL POLICY

Thank you for choosing Advanced Vein Care Solutions for your medical and surgical needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your overall treatment plan. The following is a statement of our Financial Policy, which we require every patient to read and sign prior to any treatment.

If you do not have health insurance, payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance. To assist you, we accept cash/check, MasterCard, Discover, Visa and Care Credit.

If you do have health insurance, we will file it for you as a courtesy. You must realize, however, that your insurance is a contract between you and your insurance company. Payment to us is *your* responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other health insurance companies.

If you belong to a health insurance plan that Advanced Vein Care Solutions participates with, we follow the guidelines set forth in those plans. Services cannot be rendered if you have not obtained proper authorization. **Deductibles, Co-pays, and/or Co-insurance are due at the time of service.** We do participate with Medicare, as well as a number of other health insurance plans.

We realize that temporary financial problems may affect timely payment of your account. Please contact us promptly for assistance in the management of your account. If there is no activity or correspondence on your account after 30 days, we will consider using an outside collection agency as means of collection.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns regarding the above information.

I have read the Financial Policy and I understand and agree to the Financial Policy. I further agree in the event of my non-payment, to pay the cost of an outside collection agency and/or court costs and any reasonable fees that should be required.

Patient/Responsible Party Signature:

_______________________________________ Date: ____________________