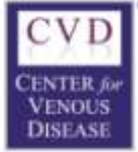


**Thank you for choosing Center for Venous Disease as your healthcare provider.**

Your signature below forms a binding agreement between Center for Venous Disease (CVD - the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical care.

- CVD is pleased to assist you by billing to our contracted insurance providers. However, the patient is required to provide us with the most correct and updated information about their insurance and any changes in phone numbers or addresses, and will be responsible for any charges incurred if the information provided is not correct or updated in a timely manner.
- Patients are responsible for the payment of their **specialist** co-pays for each office visit, coinsurance, deductibles, and complete out of pocket. (Form Attached).
- Patients may incur, and are responsible for the payment of additional charges at the discretion of CVD. These charges may include (but are not limited to):
  - Compression Stockings and/or Total Vein Care Kit
  - Charge for returned checks
  - Charge for missed appointments without 24 hours advance notice
  - Charge for extensive forms (FMLA/STD/LTD) completion
  - Any costs associated with collection of patient balances

**Patient Authorizations:**

- By my signature below, I hereby authorize CVD and the physicians, staff, and hospitals associated with CVD to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies and other third party payers, to obtain authorization for my treatment plan.
- I understand that it is ultimately my responsibility to ensure that proper authorization has been granted by my insurance company prior to my procedures. If I am treated and no authorization was obtained and the services are denied by my insurance company, I am then held financially responsible for that date of service and treatment cost.

**Patient Collections:**

<u>A portion of your patient responsibility is due prior to your procedure.</u>

A pretreatment breakdown will be given to you to assist you in planning for upcoming procedures. Deductibles and coinsurance questions can be verified by calling your member service department located on the back of your insurance card. Billed Patient balances are expected to be paid within 30 days. Our system is now set up to send all outstanding balances at 60 days old to an outside collection agency. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that CVD has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collections including, but not limited to, transfer fees.

For your convenience we do accept cash, checks, and all major credit cards. We also now offer Care Credit and have the capability, upon your approval, to set up payment arrangements that will automatically draft your banking account.

For questions regarding your out of pocket responsibilities, your insurance company can provide you an Explanation of Benefits outlining payments and patient balances, and can give you very detailed information regarding your benefits. Some questions to ask are:

- What is my deductible amount and how much has been met?
- What is my coinsurance percent?
- What is my yearly out of pocket, does that include my deductible and how much of that has been met?

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients, and that it is my responsibility to know the terms of my insurance.

SIGNED (Patient or Guarantor): ________________________________ Date: _____________

Printed Name: ______________________________________________

FOR (print patient name): _____________________________________

CVD Staff Member signature: __________________________________

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