Center for Vein Disease – Financial Policy

Thank you for choosing Center for Vein Disease. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. To keep you informed of our current office and financial policies, we ask that you please read and sign our financial acknowledgement prior to any treatment.

1. All charges, regardless of insurance coverage, are ultimately the patient's responsibility. Insurance benefits were verified as a courtesy based on the insurance policy number provided to Center for Vein Disease. Benefits and eligibility were obtained from the patient's insurance provider. At Center for Vein Disease, we encourage every patient to contact their insurance company to verify coverage.
2. Patients will be asked to provide their current insurance card and patient's current mailing address and phone number at the initial and each subsequent visit. It is the patient's obligation to inform our office of any insurance, address or telephone number changes; failure to do so, will result in the balance being patient's responsibility.
3. The patient is responsible for any service not covered by insurance carriers. Patients are responsible for knowing what services are covered under their insurance plan. Center for Vein Disease must bill the visit according to the services provided. To verify coverage and benefits, please provide the following Common Procedure Types (CPT codes):
    - Ultrasound Scan – 93971/93970
    - Compression Stockings A6534
    - Radiofrequency Ablation – 36475
    - Endovenous Adhesive Ablation – 36482
    - Endovenous Laser Ablation - 36478
    - Varithena – 36465
    - Sclerotherapy – 36471
    - Ultrasound Guided Needle Placement – 76942
    - Puncture Aspiration – 10160
4. Once your insurance has processed your claim any remaining balance is your financial responsibility under the terms of the contract with your insurance company. We expect prompt payment of any co-insurance, deductibles or any other monies due. We are required under our contract with your insurance company to collect this money from you. All balances are to be paid in full prior to your next appointment. Please be aware that some of the treatments or tests performed may not be covered by your insurance and may not be considered by your insurance to be reasonable and medically necessary.
5. Patients will receive monthly statements. Sixty days following the initial statement, if the account remains delinquent, it may be referred to outside collections and patient may be responsible for collection fees. Patient care could be terminated if account continues to remain delinquent.
6. Co-Payment: If your plan has a co-payment, you will be expected to pay at each visit. We are required under agreement with your insurance company to collect this from you.
7. For patients without insurance, full payment is expected at the time of service. We do not offer payment plans for this.

Cancellation Policy:
To ensure your quality of care and the quality of care of all other scheduled patients, we require a minimum of 48 hours notification in the event that your appointment must be rescheduled. Any patient canceling an appointment without 48 hours' notice will be charged a fifty ($50.00) cancellation fee.

- I have read, understand, and agree to the above Financial Policy.
- I understand that charges are to be paid in full at the time of service.
- I understand that all applicable coinsurance, copayments, deductibles and non-covered services are my responsibility.
- I authorize my insurance benefits to be paid directly to Center for Vein Disease.
- I authorize the Practice to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Patient Name (Please print)

Patient Signature Date