

## Notice of Office Policies

Welcome to United Vein & Vascular Centers! We are so pleased you have chosen us as your vascular healthcare provider. We would like to share the following policies with you so that you understand your responsibility regarding the charges for services rendered, notifying the office if you are unable to make your appointment, and how your protected health information will be used.

### Financial Policies

#### YOUR RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We will collect your payment at the time of your visit for all charges owed for that visit prior to meeting with your physician. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance.

#### FOR OUR PATIENTS WITH MEDICAL INSURANCE BENEFITS

As a courtesy to you, we will file a claim with your primary and secondary insurance plans. When each insurance has processed their portion of the charges, any remaining balance becomes your responsibility, and you will receive a statement from United Vein & Vascular Centers. While our billing professionals will do all they can to help you in communicating with your insurance plan, you are responsible for all charges until they are fully paid. If we do not have a contractual relationship with your insurance carrier, we will verify any out of network benefits or you will have the option to continue care as a self-pay patient. (See self-pay patient policy below). Please understand that if we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits.

##### Co-pay, co-insurance and deductible

Payment is due at the time services are rendered (co-pay, coinsurance and deductible). Patients are expected to pay their estimated portion of any services rendered at the time of their visit. Patients have an obligation under their contract with their insurance to pay their portion of healthcare expenses.

**Co-pay:** We are obligated to collect the co-pay at the time of your visit. We are required to do so by your insurance plan. The co-payment amount is determined by your individual insurance policy. If you receive two different types of services on the same day, you will be asked to pay two co-pay amounts if required by your insurance plan.

**Co-insurance:** This is the amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible and before you have met your out-of-pocket maximum before insurance pays all medical fees at 100%. The coinsurance rate is usually expressed as a percentage. For example, if the insurance company pays 80% of the claim, you pay 20%; the 20% portion is due at the time of service.

**Deductible:** This is the amount you pay each year for most eligible medical services or medications before your health plan begins to share in the cost of covered services.

At no time will co-pays, coinsurances, or deductibles be waived.

#### FOR OUR PATIENTS WITH MEDICARE BENEFITS

We are Medicare participating providers. We will bill Medicare and Medicare Supplement Insurance (Medigap) carriers. You will be asked to sign an Advance Beneficiary Notice (ABN) form if a service is not covered by Medicare, and you will be responsible for any charges associated. If you have Medicare as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim, as a courtesy, to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 45 days after we file a claim, you will be sent a bill and will be responsible for the balance.

#### FOR OUR PATIENTS WITHOUT MEDICAL INSURANCE BENEFITS or CHOOSE TO SELF-PAY

We expect patients who have no insurance coverage to pay for all services prior to receiving services. We will do our best to give you an estimate of the charges prior to your visit.

## **NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES**

Under the law, if you do not have insurance or are not using insurance to pay for your care, you have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and clinic fees. If you schedule a health service at least 3 business days in advance, you have a right to a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care service at least 10 business days in advance, you have a right to a Good Faith Estimate in writing within 3 business days after scheduling. If you receive a bill that is at least \$400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers), email [FederalPPDRQuestions@cms.hhs.gov](mailto:FederalPPDRQuestions@cms.hhs.gov), or call 1-800-985-3059.

Most insurance companies generally will not give a specific amount that they will pay until a claim is submitted, but we will obtain insurance benefits before the patient’s initial visit. Upon request, we will provide an estimate of what the patient responsibility will be.

**If you have any questions about our financial policies, please contact our Billing Department at 1-888-491-3889.**

## **Photographs, Videotaping, Recording**

Patients, family members, and/or visitors are not permitted to Photograph or Video/Audio Record other patients, visitors or UVVC staff without consent.

## **LATE ARRIVALS, CANCELLATIONS AND NO-SHOW**

At United Vein & Vascular Centers, we value each of our patients and carefully prepare for your individualized procedure. We understand that a situation may arise that could force you to cancel or postpone your procedure. Please understand, however, that your appointment date is reserved exclusively for you, meaning other patients are not offered this date and time in anticipation of your procedure. Changes to your procedure date affect your physician, insurance authorizations and other patients.

To provide the best possible care and service to all patients, we ask that you notify us at least 72-hours prior to your appointment if you need to reschedule or cancel your appointment. This notice allows us to offer your appointment slot to another patient in need of care.

We will do our best to accommodate your needs. However, please be aware that cancelling or rescheduling your appointment with less than 72-hours’ notice may result in a fee, as explained below:

***A non-refundable fee of \$50.00 will be charged to your account for the reasons listed below.***

- Less than 72-hours’ notice to cancel or reschedule your procedure.
- No show/ No Call for your scheduled procedure
- Late arrival – you arrive more than 15 minutes after your scheduled procedure time.

***The non-refundable fee of \$50.00 will be collected prior to your rescheduled appointment. Please be aware that this amount is due by you and is not billable to your insurance company.***

**My signature certifies that I have read and understand the Office and Financial Policies.**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient/Responsible Party Signature:** \_\_\_\_\_