MINIMALLY INVASIVE VASCULAR CENTER

FINANCIAL POLICY

Thank you for choosing the Minimally Invasive Vascular Centers™, as your Vascular Health Care provider. We focus on your circulation to keep you going. We are committed to the successful treatment of your condition. Payment of your bill is considered part of your treatment and a clear understanding of our financial policy is important to our professional relationship.

Payment is due at the time of service or you may be asked to reschedule your appointment.

We will bill your insurance company as a courtesy to you with a copy of your current insurance card. If we are unable to verify your insurance or you do not have your insurance card, full payment is due at the time of service. We accept cash, check, credit, and debit cards. There will be a $40 charge for returned checks. All applicable Copays and deductibles are due at the time of service.

If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility. We will not provide any procedures without full payment.

Medicare/Medicaid: We accept Medicare, Maryland and DC Medicaid plans. We accept a limited number of Managed Care Plans (MCO). To be certain that your services are covered, please confer with our front desk staff especially if you are a member of Medicare or Medicaid Managed Care Plan. As a Medicare/Medicaid patient you are responsible for your deductible and for the difference between the approved charge and the amount Medicare/Medicaid pays. If you have supplemental insurance we will bill it for you. Any remaining balance will be billed to you. All deductibles and co-pays are due at time of service.

HMO/PPO/Commercial: All co-payments and deductibles are due at the time of service. We are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan.

Workers Compensation/Auto Accident Injuries/Medical Assistance: We do not accept worker's compensation, auto insurance cases or Medical Assistance Programs. You can pay the entire fee up front and submit your receipt to your insurance carrier for payment. Reimbursement from your carrier is your responsibility.

Self-Pay: You are required to pay for all services in advance. We will not provide any services or procedures without full payment. If you cannot pay in full, you will need to set up a payment plan with our billing department prior to receiving treatment.

Delinquent accounts: Delinquent accounts may be assigned to a collection agency or submitted to small claims court. All collection costs will be added to your outstanding balance. Patients with delinquent accounts may be dismissed from our practice.

No Show Appointments: We request the courtesy of at least a 24 hour advance notice of all cancellations, if we are not notified, you will be assessed a $50 non-cancellation fee, which will be collected at your next appointment or billed directly to you.

If you are scheduled for any procedures, including, but not limited to, Arteriogram or VNUS Closure, a five Day Notification is required for cancellation or to reschedule appointment. If we are not notified, you will be assessed a $500 fee.

Consent for Medical Treatment: I authorize The Minimally Invasive Vascular Centers™ and personnel to render medical treatment and evaluation if needed for this appointment and all future appointments. I further authorize ultrasounds, injections or other diagnostic tests and treatments that may be necessary.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS: I hereby authorize the Minimally Invasive Vascular Centers™ to treat the above named patient. I authorize the release of medical information necessary to process insurance claims for treatment. Photocopies of this are valid as the original. I authorize medical benefits to be directly paid to the MIVC. I understand that I am financially responsible for any treatment not covered by my health insurance.

Printed (patient) _____

Patient DOB Printed (authorized individual) _____

Signed (patient) _____

Signed (authorized individual) _____

Date _____

Witness Date _____