VeinSpecialists
OF TAMPA

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Financial Policy

The Doctor and our staff would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read and understand the following:

It is your responsibility to inform our office of any address, telephone, or insurance coverage changes.

Your account is to be kept current. Accordingly, all self-pay or insurance co-payments, co-insurances, and deductibles will be collected at the time of service. Payments can be made by check (under $100), Visa, MasterCard, Discover, American Express, cash or by Care-Credit.

If you are unable to make your payments(s), your appointment may be rescheduled.

A returned check will result in a $50.00 service charge.

Any necessary refunds will be issued once all insurance claims are received and processed.

If requested from this office, there will be a $15.00 charge for the completion of forms (ex; Disability, FMLA, etc.)

Any unpaid balances older than 30 days may be subject to 1.5% interest per month.

If your account is turned over to a collection agency, you will be responsible for any costs incurred in conjunction with your unpaid debt. These costs may include interest, collection agencies fees up to 35% of your outstanding balance, court costs, and attorney fees.

It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your next appointment.

If your insurance policy requires a referral from your Primary Care Physician, it is your responsibility to obtain it and have it faxed prior to your appointment.

Be aware: Not all of our services are covered benefits with every insurance plan.

Our office will assist you with coverage determination, however, it is ultimately your responsibility to be aware of what service(s) are being provided to you and if it is a covered benefit under your insurance policy.

You are responsible for any non-covered charges not paid by your insurance policy.

If you have Health Insurance Coverage: We will submit your claims, however, we must emphasize that as medical provider, our relationship is with you, and not with your insurance company. Although we attempt to verify your Specialists benefits with your insurance company, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **We are here to help you.**

Vein Specialists of Tampa is committed to providing all of our patients with exceptional care. When a patient cancels a visit without giving us 24 hours notice, they prevent another patient from being seen. As of April 1, 2016, the office policy for Vein Specialists of Tampa will be as follows:

A fee of $50.00 will be charged and collected for a missed or cancelled office appointment without at least 24 hours notice to the office staff. A fee of $75.00 will be charged and collected for a missed or cancelled surgery appointment without prior 24 hour notice to our office staff. We will make exceptions to this policy for unpreventable situations that may occur.

For patients who miss or cancel 2 consecutive appointments, the 3rd appointment being scheduled will require a credit card number on file at the time of the call and should the appointment be missed or cancelled again, your credit card will be charged as outlined in the above paragraph. Once a patient has missed or cancelled 3

appointments, it will then be the decision of the physician whether to discharge the patient from the practice.

I understand that I am financially responsible for any and all charges rendered at the time of my visit. If my insurer sends payment to me directly for services provided to me by Dr Dworkin or his associates, I understand it is my responsibility to promptly forward that payment to Dr Dworkin's office.

Cellular Phone Contact Policy

By providing us with a telephone number for a cellular phone or other wireless device, you are expressly consenting to receiving communications- including but not limited to prerecorded or artificial voice message calls, text messages, and calls made by an automatic telephone dialing system- from us and our affiliates and agents at that number. This express consent applies to each such telephone number that you provide to us now or in the future and permits such calls. Calls and messages may incur access fees from your cellular service.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ SIGN: X_____

Patient Name (please print) Patient Signature

Date

_____ _____

Responsible Party (please print) Responsible Party Signature

Date