

VEIN INSTITUTE OF NEW JERSEY

Our Practice Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office administrator. We are dedicated to providing the best possible care and the essential element of your care and treatment.

Unless other arrangements have been made in advance by either yourself or your health insurance carrier, full payment is due at the time of service. For your convenience we will accept cash, check, or credit card for payment.

Your Insurance

We have made arrangements with a few insurers and health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement, however, you will be required to pay the authorized co-payment, and deductible at the time of service. It is the policy of our office to collect the co-payment and appropriate referral when you arrive for your appointment.

If you have insurance coverage with a plan we do not have a prior agreement with, then you will be responsible for payment in full at the time of service. We will, however, submit a claim to your carrier for your re-imbusement.

Effective 1/1/03 patients with Medicare as their primary insurance carrier will be required to pay at the time of service for their deductible as well as for their 20% co-insurance.

If in the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. **We reserve the right to charge interest on overdue balances and to charge for collection and/or legal fees.**

Returned Checks

A fee of \$30.00 will be charged on any checks returned by the bank for insufficient funds.

Missed Appointments

In order to provide the best possible service and availability to all of our patients, it is our policy to charge a fee of \$50.00 for any appointments not cancelled at least one day prior to the scheduled visit. Please call us and let us know if you need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by it's terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient or Guardian _____ **Date** _____

Print Name of Patient _____