

VASCULAR SURGERY ASSOCIATES, PA
VEIN INSTITUTE OF THE MIDWEST
7420 SWITZER
SHAWNEE, KS 66203
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PHONE: 913-262-9201 OR 913-322-2211

FINANCIAL POLICIES AND PROCEDURES

Insurance: As a courtesy to you (the patient), we will bill your insurance company. It is your responsibility to provide our office with a **current** copy of your insurance card and driver's license at the time of service. Failure to provide this information on a timely basis will delay your claims payment and full payment could potentially become your responsibility. Also it is your responsibility to obtain any necessary referrals and to verify your plan benefits with your insurance.

Please note that having insurance is **not a guarantee of coverage or payment** and it is your obligation to understand your plan benefits and coverage. This includes deductibles, copay/co-insurance and exclusions to your policy.

Please Note: Patients choosing to receive medical or cosmetic care for non-covered services as outlined by their insurance policy hereby agree to pay for said charges **prior** to receiving treatment.

Patient Balances: Copays are due at the time of service, we accept cash, check, Visa, MasterCard and Discover. All balances clearly stated as "patient responsibility" will be due and payable by the patient within 10 business days from receipt of their billing statement. Failure to pay your bill within the requested time frame may result in your account being assigned to an outside collection agency. The patient may incur additional collection agency fees and/or be dismissed from care with Vascular Surgery Associates, P.A. Please contact our office if special payment arrangements are needed.

When there is reasonable doubt about coverage benefits for potentially non-medically necessary treatment (as defined by your insurance plan), we will, as a courtesy to you (the patient) attempt to determine your financial responsibility for recommended treatment. **However**, our estimate of your financial responsibility **does not** constitute a contracted fee for services rendered. You will be responsible for all "patient responsibility" charges as defined by your insurance plan.

Returned Check Fee: There will be a \$30 charge for all returned checks.

Completing Insurance Forms: Vascular Surgery Associates, P.A. will complete one set of insurance forms out of courtesy. Any additional forms that you are requesting our staff to complete may incur a \$10/form charge.

I acknowledge and agree to the above financial policy.

Patient/Guardian Signature

Date