TEXAS VEIN and COSMETIC SPECIALISTS

Financial Policy – Managed Care

We are please to inform you that we participate in a contract with your insurance company. Under your plan we will file your insurance on your behalf, accept a discount off the usual and customary fee, and collect your out of pocket expenses. In order for us to provide services at a discounted fee, it is necessary for us to reduce our billing expenses. Therefore, your out-of-pockets expenses include your co-pays, deductibles, and co-insurance (example: if your plan pays 80% we will collect your co-payment, deductible, and 20% of the balance). We will estimate your out of pocket expenses as closely as possible based on the individual fee schedule provided by your insurance company. If your insurance company has not provided a fee schedule for us, we will estimate a discount based on the average discount of all our managed care contracts.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract or exactly what benefits are included or excluded in your plan. Be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. In the event that you do not have benefits for what you were seen for, the balance is your responsibility.

We will file a claim for covered services for each claim with our usual and customary charge to your insurance company. We will file up to two separate insurance companies claims for patients that have primary and secondary insurances. During the processing time, you will receive statements from our office. However, unless your statement reflects amount due by you, the statement is only informational. If your insurance company sends forms to you requesting additional information from you, your prompt reply is necessary. We ask that you return the information to your insurance by certified mail return receipt. If your insurance company does not receive this information, you will be responsible for payment of the full charges, and no discount will be applied.

Once your insurance company has processed your claim, and all charges, payments, and discounts have been applied to your account, we will notify you by mail of any further balance due. Any balance remaining is due and payable in full within 30 days of receipt of this notification. If extended payments are needed on large balances, our account representative will discuss payment plan options with you. If you discover an error on your bill, please contact our account representative. We will refund any overpayments due to you within 30 days provided no other claims are pending.

Referral /Authorizations:
If your insurance requires that you obtain a referral/authorization to be seen, all documentation is your responsibility. Please understand that if you elect to be seen without a valid referral, or you have changed Primary Care Providers without obtaining a new referral/authorization, or your referral/authorization has expired, your services will be considered non-covered under your HMO/POS, and you will be responsible for payment of our full charges and no discount will be applied. If out of network benefits are available under your policy, the portion you are responsible for paying will be higher than if you had obtained a referral/authorization.

_____ **Procedures**:
Procedures performed in our office may require a separate and distinctive referral/authorization. Services at our office will usually consist of 1.) the office visit and 2.) in office ultrasound or PPG, performed on your initial visit. Once the initial evaluation is performed and an assessment is obtained all procedures to be performed are done within our office. This will require a separate referral/authorization. Our office will start the process of obtaining your referral/authorization for surgery. Even though this procedure is being performed within the office, some insurance companies may consider some of the services rendered subject to a separate deductible and co-insurance rather than your co-pay. Should this be the case with your carrier, you will be notified accordingly.

_____ _____
Signature of Patient/Responsible Person on Account Date

Pre-existing Clause:
Your insurance plan may include a pre-existing clause, which states that your insurance company will not pay for treatment of certain conditions that have been previously treated up to a specific length of time prior to your effective date of coverage. If your insurance includes a pre-existing clause, and investigates your claim and determines your services to be non-covered, you will be responsible for payment in full within 30 days and no discount will apply.

Please read this policy carefully. If you have any questions regarding our policy, please ask to speak to our business office. Your signature on this page constitutes an agreement to this policy and the authorization below.

Patient Certification and Authorization:
I authorize the release of any medical or other information necessary to process my claim(s). I also authorize payment of insurance medical benefits to Michael F. Bardwil, M.D. for all outstanding services rendered to me. I certify that I have read and understand this policy.

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Signature of Patient/Responsible Person on Account Date