Buffalo Vascular Care

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BVC Financial Policy

Patient: _____

VASCULAR INTERVENTIONAL ASSOCIATES-FINANCIAL POLICY
Welcome to VIA. In order for our medical staff to be able to deliver the quality of care that you deserve and are accustomed to; we have established our financial policies explained below. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE YOUR UNDERSTANDING BY SIGNING BELOW.

1. We require that you present **photo identification** and your **insurance card** at each visit. It is your responsibility to provide us with the correct information to bill your insurance, if changes have been made regarding your insurance information, you are expected to notify us before any future appointments. If you do not present with accurate insurance information, you will be billed for any services rendered to you.
2. If you have a **change of address or telephone numbers**, please notify the receptionist.
3. **Co-pays** are expected at the time of service. We will also collect for non-covered services at the time of your visit. If you have a balance from a previous appointment, you will be expected to make payment. We accept cash, checks or credit cards.
4. **Deductibles**: this is an out-of-pocket expense required by certain insurance plans, before they will cover remaining medical costs. It is your responsibility to be aware and have an understanding of your insurance deductible. It is a requirement that payments toward your deductible be made. If payment is not received we will be forced to submit your account to collections.
   - For patients with a **High Deductible**, you will be notified prior to your visit what amount remains on your current deductible and the amount that is expected at the time of service. once you are notified, we will be more than willing to discuss payment plan options. It will be required that payment be made every month when your statement is.

INITIAL HERE _____

5. **Referrals:** it is ultimately your responsibility to know whether or not your insurance requires that you obtain a written referral to be treated by our physicians. If a referral is required, this must be obtained before you are seen in our offices. If you present for an appointment without your required referral please know that you will be held financially responsible for the balance of any services rendered to you.
6. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered.
7. If your insurance denies our charges, does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency and be reported to the credit bureau, unless prior arrangements are made with our billing service. Patients will be responsible for legal/collection fees.
   - Please be aware that our billing department is happy to work with you to meet your needs. We are more than understanding when it comes to the cost of Healthcare; which prompted us to begin offering a payment plan for patients with a high balance. Please do not hesitate to contact billing to discuss a possible payment plan that works for you! They can be reached Monday - Friday 8:00am to 4:00pm at 716-852-1977.
8. It is our office policy that all past due accounts will be sent 3 statements. At this time, if payment has not been made, you will receive a letter warning you that if you do not contact the office within 30 days we will be forced to surrender your account to the Collections Agency. If after receiving this letter you still do not contact the office to set up a payment plan, your account will go to Collections.
9. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of services. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
10. HMO-PPO PATIENTS: We will bill your insurance for you. Your co-payment will be collected at the time of service no exceptions.
11. SELF-PAY PATIENTS: Self-pay accounts are patients without insurance coverage or patients who are covered by an insurance that is not accepted by our office. Patients who are self-pay will be expected to pay a fee at 80% of the amount owed to us, this will be paid at the time of service. It is also required that if you are a self-pay patient, our billing department must be notified, and you must meet with them to create a payment arrangement.
12. **MISSED APPOINTMENTS:** Patients are required to notify our office at least **24 hours** in advance if you need to reschedule or cancel an appointment. We will charge a fee for any patient who misses an appointment without calling in advance. The NO-SHOW fees are as follows: $50 will be charged for all office evaluations. $100 will be charged for all procedures. If you have more than two appointments that were missed, you may be discharged from the practice for non-compliance.
13. Minors: the parent(s) or guardian(s) are responsible for full payment and will receive the billing statements. A signed release may be required for unaccompanied minors.

(continued on next page, signature **REQUIRED**)

14. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is the patient's responsibility to be aware of their insurance coverage, policy provisions, authorization requirements, as well as network providers if applicable. We cannon guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanations should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation. We participate with many insurance companies. Due to relationships between insurers, third party administrators and "umbrella" networks, patients are strongly advised to contact their insurance carrier for participating provider information. We will bill non-participating insurance companies as a courtesy to you. If we have not received payment from a non-participating insurance company within 60 days of the date of service, you will be expected to pay the balance. We will provide you with all necessary information for submitting claims to your insurance company.

CONSENT/AUTHORIZATION FOR TREATMENT AND TO RELEASE INFORMATION/DISCLOSE PERSONAL HEALTH INFORMATION:

I hereby agree that Vascular Interventional Associates may perform care and treatment, and may conduct such examinations, lab tests, and procedures as may be by my physician or treating practitioner.

I hereby consent to the use and disclosure of my protected health information, by VIA, for purposes of treatment, payment, and health care operations. Any release of my medical records and Protected Health Information will be made according to state and federal regulations. I understand that VIA may release medical information to any third party which may be responsible for payment of my medical expenses.

I also understand that whether I do or do not have insurance, I am ultimately responsible for payment for any services rendered to me by VIA's Providers.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize my insurance benefits to be paid to Vascular Interventional Associates.

I have read and have a full understanding of Vascular Interventional Associates Financial Policy.

PLEASE SIGN HERE: _____

Date: _____

If you have any questions regarding our financial policy, please contact our billing department at (716) 852-1977.