INSURANCE INFORMATION AND FINANCIAL POLICY
CALIFORNIA VASCULAR AND VEIN CENTER, INC.

Patient Name:_____ Account Number_____

Thank you for choosing **California Vascular & Vein Center** as your health care provider. We are committed to making health care less stressful and more effective by clarifying financial responsibilities in advanced. **Please read both sides of this form, sign where designated, and return this form to our office**. We are happy to answer any questions you may have; please dial 1 - (661) 873 - 4216 to speak with our Business Office Personnel.

INSURANCE INFORMATION

The following is a summary of our office policy as it pertains to insurance coverage:

Contracted Private Insurance:
We contract or participate with private insurance including: Blue Shield Foundation for Medical Care, Blue Cross Prudent Buyer, as well as programs participating with Kern County Area Independent Practice Associations. If you are a member of one of the plans we contract with, we will accept payment at the level allowed by your program (except if you have multiple insurances,) although you will be responsible for any deductible, co-payment for co-insurance required by your plan. Necessary adjustments to our billed charges will be made after payment is received from the payer. Please check with our Business Office personnel to verify if we contract with your program.

Other private Insurance: We will assist you by billing your insurance company. However, you are responsible for all charges billed to you. We reserve the right to ask you to pay a deposit before services are rendered. We find that most insurance companies only cover a portion of your medical expenses and you will have some balance to pay.

Medicare Patients: Our office is a participating Medicare physician. As such, Medicare patients will only be required to pay the difference between what Medicare allows and the amount paid by Medicare, which is the Medicare co-insurance and deductible.
Necessary adjustments in our billed charges will be made after payment from Medicare is received.

Co-Payments: If your health plan requires a co-payment at the time of service, please be prepared to make the appropriate payment.

FINANCIAL INFORMATION

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for a payment. You are responsible for the bill.

Some companies pay fixed allowances for certain procedures; others pay a percentage of charges. For insurances with which we contract, we will adjust your balance due according to our contract with the insurance carrier. It is your responsibility to pay any deductible, co-payment, co-insurance and any balance not paid by your insurance that we are not required to adjust.

It is your responsibility to provide us with all information we may require to properly submit claims on your behalf. We will work with your insurance company within reason. However, you are responsible for charges for service you incur. Should you have any questions, please feel free to discuss them with a member of our Business Office staff.

Terms of Payment: All balances are due within 30 days of the statement date. You may pay by cash, check, Visa or Master Card. If your account is assigned to an attorney for collection and /or suit, the prevailing party shall be entitled to reasonable attorney fees and cost of collection.

I have read the insurance information and Financial Responsibility statement and understand its contents.

Signature of Patient (Responsible Party)_____Date_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and /or surgical benefits to which CALIFORNIA VASCULAR & VEIN CENTER is due for my bill. This assignment will remain in effect until revoked by myself in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

Date:_____ Patient's Signature:_____
Insured's Signature:_____

MEDICARE ASSIGNMENT

If you have Medicare, please sign the following:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to CALIFORNIA VASULAR & VEIN CENTER for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.
If other health insurance coverage is indicated in item 9 of the HCFA – 1500 claim form or elsewhere on their approved claim forms or electronically submitted claims, my signature authorize releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient
Signature:_____Date:_____

If signature is other than patient's signature, write in patient's name followed by signature of person signing, and complete the following:

Name of signing party:_____

Address of signing party:_____

Relationship to patient:_____

Reason patient could not sign:_____

CONSENT TO RELEASE INFORMATION

I hereby authorize CALIFORNIA VASCULAR & VEIN CENTER to furnish information to any referring physician,
agency, or insurance company(s) I have listed on the Patient Information Form.

Date:_____ Patient Signature:_____

For a copy of this financial policy document, please request a copy from our receptionist.

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING OUR FILES