VEIN Atlanta, LLC
Office/Financial Policy Agreement

Thank you for choosing Vein Atlanta for your medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this Office/Financial policy Agreement. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care.

Payment is required at the time of services are provided unless other arrangements have been made in advance. We accept cash, money orders, and all major credit/debit cards. There is a **$30.00** service charge for returned checks.

INSURANCE: We participate in most major insurance plans and will bill your insurance plan as may be necessary. If we do not participate with your plan, payment in full is required at the time of service unless other arrangements have been made in advance. Knowing your insurance benefits--including referral, eligibility, covered benefits, and medically necessary procedures is ***your*** responsibility; please contact customer services at your insurance company for questions regarding your coverage. ***You are responsible for any charges not covered by your plan.***

Remember that insurance authorization/referrals for services ***do not guarantee payment***. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. We require you pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. Should your account become delinquent and be referred to an outside collection agency, you shall be financially responsible for the costs of collection and/or legal fees.

Cancellation Policy

Time has been specifically reserved for your appointment, procedure or treatment. Please call at least 2 business days ahead of time if you must cancel an appointment. There is a $50 charge for office visits and $100 charge for procedure visits, including Sclerotherapy visits if you do not show up for a scheduled appointment or cancel within 2 business days prior to your scheduled appointment.

By signing below, I acknowledge that I have read, understand, and agree to comply with the terms of your Office/Financial Policy and the Cancelation Policy.

Patient Signature: _____ Date: _____