inovia
VEIN SPECIALTY CENTER

Inovia Vein Specialty Center is committed to providing our patients with the best possible care and service to you. Understanding our financial policy is an essential element of your care and treatment in our office.

- Please bring a photo I.D. and your current insurance card(s) with visible identification numbers to every appointment.
- You will be charged for each office visit, test, procedure, and surgery, unless you are specifically notified otherwise. The amount of the charge depends on the time spent and the specific treatment. We can estimate but we cannot predict accurately what those charges will be until after your appointment.
- As a courtesy, we will bill (most) your insurance company if you provide us with valid insurance card(s) at the time of service. Verification of benefits is the patient's responsibility, as only the insurance company can guarantee your coverage.
- For office visits and ultrasounds, we are required by insurance companies to collect your copay at the time of service. If your copay is not received when due, you may be subject to a $25 late fee in addition to your copay.
- For procedures (RFA, Phlebectomy, and Sclerotherapy), compression stockings and other durable goods, we will prepare an estimate of your balance based on your insurance benefits. That Estimated Balance is due at time of service. Please bring your Estimated Balance with you for your procedure appointment.
- Cancellation of a procedure within 24 hours of scheduled time will result in a $200 cancellation fee.
- **We will send you a statement of your actual balance approximately 40 days following the date of service. Any remaining patient balance is due upon receipt of our statement. Any overpayment by you will be promptly refunded to you.**
- Payment is accepted by cash, check, and debit/credit Visa or Mastercard. There will be a $25.00 charge for checks returned for insufficient funds.
- Accompanying adults will be responsible for payment of services rendered on a minor patient (under18 years of age).
- Insurance reimbursement is a result of a contract between you and your insurance carrier. If they do not pay within a 75 day period, we will look to you for payment. If this results in overpayment on your account, Inovia will refund to you any overpayment once the insurer pays.
- **If we must-rebill you because you did not pay your bill, we will charge a re-processing fee of $7.50 per month.**
- **If after making payment arrangements, your account balance is not paid within 6 months, your account will be subject to normal collection procedures. Account balances turned over to a collection agency will result in a $50 fee.**

- Extending credit to you is a courtesy. We reserve the right to revoke the privilege if the account is not maintained in a current status, or other circumstances arise wherein the owner/manager deems a creditor/debtor relationship is inappropriate. Determination will be made on an individual basis.

I have read and understand the above financial policy of Inovia. By signing below and accepting treatment at Inovia, I am indicating I agree to comply with the above financial policy.

Signature of responsible party_____ Date_____

Medicare Patients

- Medicare requires us to have your Medicare ID card on file in order to bill; if we do not have your current Medicare ID card on file, we will look to you for payment.
- We accept Medicare assignment; Inovia will send a statement to Medicare patients after Medicare pays its 80% on rendered services. Your 20% co-insurance is expected upon receipt of our statement if there is no secondary insurance.
- If you do have secondary insurance, we will look to you for payment if your secondary insurance has not paid 30 days after Medicare payment is received in our office.
- Non-covered services on Medicare patients are due at the time of service.

Signature of responsible party_____ Date_____

For Medicare Patients only:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Inovia, LLC for any services furnished me by that physician group 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 to pay the claims. If other health insurance coverage is indicated in item 9 on the HCFA-1500 claim form or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare-assigned cases, the physician group 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. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature of responsible party_____ Date_____

If you have any questions concerning Inovia's financial policy or need to make payment arrangements, please call our billing department directly at (541) 420-9897.