

# **MONTGOMERY VASCULAR SURGERY, P.C.**

## **FINANCIAL POLICY**

*Thank you for selecting our office for your medical care. In order to prevent any misunderstandings concerning the responsibility for payment of medical and surgical services provided to our patients, the following is supplied: **Please understand that our service agreement is with YOU and NOT your insurance company.** Just as you have chosen your insurance coverage, you are responsible for payment for the service(s) rendered. Any claims filed by us are done as a courtesy.*

### **ASSIGNMENT OF BENEFITS**

For services received, I hereby authorize and direct that payment(s) be made directly to **Montgomery Vascular Surgery** for benefits payable under the terms of my policy. I recognize that if payment is made directly to me, the amount received, up to the amount due for services rendered, is the property of **Montgomery Vascular Surgery** and should be paid over to **Montgomery Vascular Surgery** immediately. I understand that I am financially responsible for charges not paid by this assignment.

### **MEDICARE**

We are participating providers and accept the Medicare approved amount as the total charge for Medicare covered patients. **Please remember that if you only have Medicare, the remaining 20% of the allowable fee is the patient's responsibility.** We will be glad to assist you in setting up a payment plan if needed.

### **MEDICAID**

If you are a Medicaid recipient, please provide us with your card to verify eligibility and your **\$1.00** co-pay at the time of service if applicable. If you have Medicaid coverage pending, we require payment for the services at the time of your visit. If it becomes retroactive and Medicaid pays for your services, we will refund your payments in coordination to what Medicaid has covered.

### **OTHER INSURANCES**

Co-payments for office visits are required at the time of service. After filing with your insurance, if a deductible is put to your responsibility, prompt payment is required. For your convenience, we are pleased to accept Visa or MasterCard.

### **REFERRALS**

It is your responsibility to bring any required referrals for treatment, at, or prior to the visit.

**If you do not have the referral, you may be asked to reschedule your appointment until one is acquired.**

### **RETURNED CHECKS AND DELINQUENT ACCOUNTS**

There will be a **\$25.00** charge for all returned checks. If your account becomes delinquent and must be placed with a collection agency, you will be responsible for all reasonable attorney/collection fees.

### **PRIOR CONSENT TO CONTACT BY CELL PHONE**

You agree, in order for us to service your account or collect monies you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

\*I have read and understand my financial responsibilities to Montgomery Vascular Surgery.

\*\*I/We have read this disclosure and agree that Montgomery Vascular Surgery, its employees and/or agents may contact me/us as described above.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_