



# SANTA BARBARA - VEIN CENTER -

## CONDITIONS OF SERVICE FINANCIAL POLICY HIPAA POLICY ACKNOWLEDGMENT

Thank you for choosing Santa Barbara Vein Center. This document represents our established *Conditions of Service* that will be used to resolve any issues or disputes pertaining to vein care services rendered by SBVC. We ask you to read, sign, and return this agreement prior to any treatment.

**CONSENT TO TREATMENT:** The patient identified below consents to therapeutic vein care evaluations and treatment which may be performed or assisted by SBVC vein specialists while under the care of either Dr. Phillip West or Dr. David Kolegraff and/or their staff. These evaluations and treatments may include, but are not limited to, initial evaluation or consultation, history and physical examination, lower extremity venous ultrasound study, infiltration of tumescent local anesthesia, endovenous laser ablation (EVLA), ultrasound-guided sclerotherapy, vein light sclerotherapy, and/or conservative vein therapy.

**PAYMENTS:** **SBVC participates with many insurance plans as a convenience to our patients. Your copayment and/or deductibles are determined by your insurance company. Our contracts require that all medical facilities collect these fees, to ensure the insurance policy is enforced. Please understand that payment of your bill is considered in part the responsibility of the patient. Payment, according to the policies below, is due at the time of service. We accept cash, checks, Care Credit, Visa, and Master Card. "Bounced Checks" will be charged a \$50.00 fee and if not paid within 10 days will be referred to Santa Barbara County Court for legal action-it is your responsibility to contact us as soon as you are aware that your check has been rejected for payment. Also if you write a bad check you will be required to pay via cash or credit card.**

**PATIENTS WITH INSURANCE:** **In order for us to correctly bill your insurance company we will need complete information and this signed Financial Policy form to allow payment to be made directly to our office. You are responsible for any charges your insurance does not cover; i.e.: deductibles, co-pays, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and co-insurance amounts at the time services are rendered. The remaining balance should be paid within one (1) month of notice from insurance company. By law your insurance company is required to remit payment or deny claims within 30 days of submittal.**

**PATIENT WITHOUT INSURANCE:** **Payment in full is due at the time of service. If you are unable to pay the entire balance at the time of service, you can apply for Care Credit-a medical credit card or make monthly payments prior to having the procedure. We will not do any procedures/surgeries without having full payment.**

**WORK-RELATED/AUTO ACCIDENT INJURIES/MEDICAL ASSISTANCE:** We do not accept worker's compensation, auto insurance cases or Medical Assistance Programs. You may see our surgeons and pay the entire fee up front and submit your receipt to your insurance carrier for payment. It is your responsibility to speak to your carrier about reimbursement.

**MEDICARE: Our office will submit your Medicare charges to Medicare and your secondary insurance if applicable. You are responsible for deductibles, co-pays and any non-covered services. If you do not have a secondary insurance we will collect your 20% co-pay at the time of service.**

**MISSED APPOINTMENTS: Office Visits, Follow ups and Vascular Labs: Please notify this office at least 48 hours in advance of any cancellations.** If not notified you will be charged a \$25.00 fee. Patients having any procedure (including, but not limited to EVLA and Phlebectomy:) a 48 hr notification is required for cancellation or to reschedule an appointment. If not notified a \$100.00 fee will be charged. **Cosmetic Procedures: (including but not limited to Sclerotherapy) will be charged a fee of \$50.00 if not given at least 48 hr notice. Please help us serve you and all of our patients better by keeping scheduled appointments.**

**PERSONAL VALUABLES:** It is understood and agreed that Santa Barbara Vein Center shall not be liable for the loss or damage to any money, jewelry, documents, fur garments, dentures, eye glasses, hearing aids, prosthetics, or other personal property.

**CONSENT TO PHOTOGRAPH/VIDEO TAPING:** Santa Barbara Vein Center is permitted to take pictures of the medical or surgical progress involving vein care. The patient consents to photography and/or video-taping during medical or surgical procedures and the use of same for scientific, educational or medical research purposes. The patient further consents to routine photo documentation related to patient care.

**SEVERABILITY:** If any terms or conditions of this agreement are held by a court of law to be invalid or unenforceable, then this agreement, including all of the remaining terms and conditions, will remain in full force and effect as if such invalid or unenforceable term or condition had never been included. My signature below acknowledges that I have received a copy of this document and accept its terms.

**RELEASE OF INFORMATION: I authorize Santa Barbara Vein Center to release my insurance carrier(s) and its agents and/or my Medigap insurer any information needed to determine benefits or benefits payable to SBVC for related services.**

**DEFAULT: I understand that regardless of insurance coverage, that if after default my account is placed in the hands of an attorney or collection agency for collection, the undersigned agrees to pay for any unpaid balance and all attorney and/or collection fees.**

Thank you for taking the time to read and understand our Financial Policy. Our practice believes good communications is essential in our relationship with our patients. Please let us know if you have any questions or concerns before signing below. Your signature indicates that you have read this policy and understand and agree to its terms.

\_\_\_\_\_ I have read and agree to the Financial Policy and Release Information paragraphs  
(initial) stated above

\_\_\_\_\_ I have been offered/given a copy of SBVC HIPAA Policy and Patient's Rights and  
(initial) Responsibilities and I have been given the opportunity to ask questions.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print

\_\_\_\_\_  
Date