**Assignment of**
**Benefits &**
**Financial Policy**

1. **Co-payments**. Copays are due at the time of service. If you are unable to make your copay at the time of service, Desert Vein & Vascular Institute (DVVI) reserves the right to reschedule your appointment until a time that you are able to make your copay. Payments for any outstanding balances are due at your appointment.
2. **No Show Policy.** DVVI staff will call, email and/or text to remind you of your upcoming appointment. If you do not call us to cancel within 24 hours of your scheduled appointment, Desert Vein & Vascular Institute will bill you a $50.00 "No Show" fee.
3. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
4. **Coverage Changes and Timely Submission**. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which DVVI must submit a claim on your behalf to your insurer. If DVVI is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
5. **Self-Pay**. If you do not have health insurance, or if your health insurance will not pay for the services rendered by DVVI, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule. Self-Pay patients are expected to make payment-in-full at the time of service, unless arrangements have been made with DVVI management.
6. **Insurance Plan Participation**. We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan.
7. **Advanced Patient Notice for Use of Non-Participating Providers and/or Facilities.** Your provider may refer you to a non-participating physician/facility or other type of provider for certain healthcare services. You have the right to receive services at a participating provider in order to obtain full benefits under your health coverage. It is important that you are fully aware of the financial implications of utilizing non-contracted entities. In order to assist you in making informed decisions regarding your health care, we ask that you sign this form to indicate you have had a discussion with your health care professional about your options and you have agreed to receive services from a non-participating provider/facility. With this notice, you acknowledge that a non-contracted physician, facility or other health care provider will be involved in your care on this date of service and you understand that this health care provider/facility is not a participating provider in your insurance network. You have been provided and have declined the opportunity to select a participating provider to provide these health care services and are voluntarily choosing to obtain services from a non-participating provider/facility. You are aware that you may be responsible for any additional costs resulting from the use of a non-participating provider /facility. You have also been advised the non-participating provider/facility is prohibited from waiving copayments, deductibles, coinsurance with the exception to special circumstances (ie: financial hardship).
8. **Referrals**. Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by DVVI, it is your responsibility to be aware of this and to obtain this referral.
9. **Prior Authorization and Non-Covered Services**. DVVI may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. DVVI, as a courtesy to our patients makes a good faith effort to determine if services we order are covered by your insurance plan, and if so, whether or not prior authorization is required, we will attempt to obtain such authorization on your behalf.
10. **Out of Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to DVVI immediately.
11. **Reassignment of Balances**. If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.
12. **Collection of Unpaid Accounts**. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and /or an attorney, which may result in reporting to credit bureaus and/or legal action. DVVI reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay DVVI for any expenses incurred to collect on your account, including reasonable attorneys' fees and collection costs.
13. **Insufficient Funds or Returned Checks.** Returned checks will be subject to a $35 returned check fee.
14. **Refunds for Cancellations** Refunds for overpayment or prepayment on canceled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow 30 days for your request to be processed. Send request to DVVI Attn: Billing Department, 14155 N 83rd Ave, Suite 136, Peoria, AZ 85381.
15. **Statements**. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates. I have read and understand the financial policy of DVVI. I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Desert Vein & Vascular Institute. I understand that I am financially responsible for all services I receive from Desert Vein & Vascular Institute. This financial policy is binding upon you and your estate, executor's and/or administrators, if applicable.

Patient Name (Print): _____

Patient Sign: _____ Date: _____