

# FINANCIAL POLICY



## **Free Screening**

Your very first visit to our office is considered a Free Screening for which there is absolutely no charge to you the patient, or to your insurance company.

At your first visit you will be asked to provide your Insurance Card(s) and give all necessary information relating to the policy holder in order for us to file a claim with your insurance company for your future visits.

## **Medically Necessary Visits / Estimates and Payment**

If you will be returning for medically necessary, diagnostic ultrasound or treatment, our billing office will do a comprehensive benefit check prior to your next visit.

If your insurance company informs us that you will be responsible for anything other than a co-payment for your next visit, you will be called with an estimate. We do this as a courtesy to give you notice of charges that will need to be collected at the time of your appointment. It is our policy to collect co-payments, deductibles and co-insurance at the time of your appointment.

Please understand that while we will try to give an accurate estimate of your out of pocket cost, there may be additional cost to you once your claim is processed by your insurance company. If this is the case you will be billed for the additional amount. Any charges billed to you will be due within 15 days of receiving the statement.

If you have made an over-payment and your account shows a credit once all procedures and visits are complete, we will happily issue you a refund. These refunds are processed by our office once a month.

## **Deposit and Cancellation Policy**

In order to provide outstanding patient services within our office setting, we do require a deposit at the time of scheduling an appointment for ultrasound, pre-operative visits, and all medical procedures. This deposit will help to offset costs incurred by our office when appointments are cancelled at short notice.

Deposits will **not** be cashed or charged by our office **unless** you fail to give sufficient notice to cancel your appointment.

For an ultrasound or pre-operative appointment you must give at least **48 hours** notice of cancellation or need to reschedule. The deposit for these visits is **\$50.00**

For procedures you must give at least **72 hours** notice of cancellation or need to reschedule. The deposit for procedures is **\$250.00**

In most cases the deposit will be collected at the time you schedule your appointment, but should we not collect from you at this time, and you cancel your appointment within 48 hours for ultrasound or pre-op visits, or 72 hours for procedures, you will be billed the charges for the cancellation.

## **Insurance Billing**

We will make every reasonable effort to work with your insurance company to collect payment for your medically necessary visits to Vanishing Veins. We seek prior authorizations whenever required by your insurance company and our providers make detailed reports of your condition which may accompany your claims to show the medical necessity for your procedure.

In the event that an insurance company denies payment or makes only a partial payment, you will be responsible for the full amount of charges or any remaining balance on the account.

## **Method of Payment**

We accept all major credit cards, personal checks and cash. We also offer a financing program through Care Credit which offers zero or low interest payment options. If you are interested in applying for Care Credit, please ask, or refer to the pamphlets displayed at our front desk. We will be happy to assist you with your application.

## **Cosmetic Visits**

If you will be returning for only cosmetic services, there will be no insurance benefit check as these charges are not payable by insurance. You will however be given a price or estimate upon request prior to your treatment. Payment for all cosmetic procedures is to be made in full on the day of the visit.

---

If you have questions relating to our financial policy please call our billing department  
480-467-2167

---



**By signing this form, you acknowledge receipt of and agreement to the terms of  
Vanishing Veins of AZ Financial Policy  
We encourage you to read it in full.**

I \_\_\_\_\_  
Print Name

Acknowledge receipt of the Vanishing Veins Financial Policy and agree to abide by the terms thereof.

Signature: \_\_\_\_\_  
Patient/ Guardian/ Guarantor

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