TRIANGLE VEIN CLINIC

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POLICIES AND PROCEDURES

Triangle Vein Clinic, a division of Triangle Surgical Associates, P.A. ("TSA"), provides the best medical/surgical care possible to our patients. We have established policies with the intent to provide clarity through the business processes. We encourage you to discuss any questions you may have regarding our policies with our administrative staff.

INSURANCE

We participate in a variety of insurance plans and will directly bill your insurance carrier under these plans. In order to honor your insurance benefits, please provide insurance identification for verification of coverage by our office. We will accept assignment of benefits for those insurance companies with whom we are contracted as in-network providers. We will file primary and secondary medical claims for all plans with whom we are currently contracted. You may be requested to complete a waiver for those services that may not be covered by your insurance plan. We cannot accept responsibility for negotiating claims with insurance companies. You are responsible for payment of all co-payments, deductibles and procedures not covered by your insurance carrier. All outstanding balances, regardless of insurance status, are to be paid within 45 days. By my signature and copies thereof, I authorize payment directly to Triangle Surgical Associates, P.A. of benefits otherwise payable to me. You will need to make payment for any claims submitted wherein you will be reimbursed directly from your insurance carrier. Your medical coverage plan is a contract between you and your insurance carrier. We cannot guarantee payment of your benefits. With regard to a minor patient, the undersigned is responsible for payment. We accept, cash, check, MasterCard, VISA, and debit card. Requests for duplicate forms or processing additional information such as life insurance, and disability forms will be charged a fee for professional time involved.

REFERRALS/AUTHORIZATIONS

If you are a member of a managed care plan that requires a prior referral to see a specialist, you are responsible for obtaining the initial and any subsequent referrals required. Our clinical staff will be happy to assist you with authorizations prior to treatment(s). Failure to obtain a valid referral/authorization may result in your financial responsibility for all charges incurred.

OUT-OF-NETWORK AND SELF-PAY

Out-of-network and self-pay patients are responsible for payment in full at the time services are rendered for all procedures. With regard to a minor patient, the undersigned is responsible for payment. We accept, cash, check, MasterCard, VISA, and debit card.

MISSED APPOINTMENTS/CANCELLATIONS

It is our policy for patients undergoing sclerotherapy to be charged for appointments cancelled with less than 48 hours notice. The missed appointment/cancellation will be subject to a penalty of 20% of the intended office service. All other patients will be charged a fee of $35 for appointments cancelled with less than 24 hours notice. This fee cannot be charged to your insurance carrier. Patients who repeatedly miss appointments may be asked to pursue treatment on a non-scheduled time, as available.

VNUS Patients: Because of the number of appointments involved, patients who cancel procedures for other than medical reasons with less than two (2) weeks notice will be charged $300.00. This fee cannot be charged to your insurance carrier. Be very sure appointment times are acceptable at the time of initial scheduling.

INSUFFICIENT FUNDS

It is our policy to charge a fee of $25 for all returned checks due to insufficient funds, or any stopped payment on an issued check.

BILLING

You will receive a monthly statement showing your balance and indicating whether insurance has been filed. You will be responsible for any unpaid balance after 45 days. Should it become necessary for our office to seek legal assistance for any unpaid fees, you will be responsible for these additional charges and interest at a rate of 15%. You will be responsible for the provider's fee, plus expenses, should a court appearance become necessary. Unpaid balances older than 90 days will be subject to an interest rate of 1.5%. Services may be interrupted until payment is made.

REFUNDS

It is not our policy to issue refunds unless your account has a credit balance and all claims have been paid. Refund checks are cut at the end of the month.

PROTECTED HEALTH INFORMATION (PHI)

The documents and materials contained in the patient's medical record which may include, but are not limited to, paper, digital or electronic correspondence, photographs/radiographs are confidential. TSA will retain the ownership rights to these photographs, digital or electronic correspondence, or other images, and the patient will be allowed access to view them or obtain copies. Reasonable copy fees will be charged. These images will be stored in a secure manner that will protect patient privacy and they will be kept for the time period required by law or outlined in TSA's policy.

All documents and materials in the medical record that identify the patient will be released and/or used in accordance with the Notice of Privacy Policy. The Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you (including demographic information that may identify you) and relates to your past, present or future physical/mental health/condition and related health care services.

You may obtain the Notice of Privacy Practice by accessing our web site www.triangleveins.com**,** at the time of your office visit, or by request any time. In-office laminated copies are located in the green binders in our reception area.

I acknowledge that I have read (or had the opportunity to read if I so chose) the Notice of Privacy Practice.

I also have read, understand and agree to comply with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

PATIENT NAME_____ ACCT #_____

PATIENT SIGNATURE_____ DATE_____

PARENT OR AUTHORIZED REPRESENTATIVE_____