1-866-695-8346

FINANCIAL POLICY ACKNOWLEDGMENT

Maryland Surgical Care, PC (MSC), MSC Ambulatory Surgical Center, LLC (MSC ASC) and/or Capitol Vein & Laser Centers (CVL) welcomes you to our practice. One of our goals is good communication with our patients, their families and/or caregivers. The following is a statement of our Financial Policy, which we ask you to read, sign, and turn into our Front Desk prior to any treatment.

PAYMENTS: **MSC & MSC ASC participates with many insurance plans as a convenience to our patients. Your co-payment 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, Master Card and Discover. "Bounced Checks" **will be charged a** $50.00 fee **and if not paid within 10 days will be referred to Frederick County Court for Legal Action-** it is your responsibility to contact us as soon as your 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, coinsurance 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. Cosmetic services are to be paid in full; we do not issue refunds or credits for unused portions of packages.**

WORK-RELATED / AUTO ACCIDENT INJURIES: We do not accept worker's compensation or auto insurance cases. You may see our surgeons and pay the entire fee up front and submit your receipt to you 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 $50.00 fee. Procedures: Patients having any procedure (including, but not limited to, VNUS Closure 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. **C**osmetic Procedures: (including but not limited to IPL, Laser Hair Removal, Fraxel, Sclerotherapy, etc) will be charge a fee of $50.00 if not given at least 48 hrs notice**. Please help us serve you and all of our patients better by keeping scheduled appointments.**

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

DEFAULT: **I understand that regardless of insurance coverage, that if after default your 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 communication 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 stated above

Printed Name:_____

Signature:_____ **Date:**_____