



CONDITIONS OF SERVICE

Thank you for choosing Vein Treatment Specialists, PC for your care. The following are our established conditions of services that will be followed in resolving all issues for services rendered by our physician and staff.

CONSENT TO TREATMENT

The patient identified below consents to the examinations, treatments and procedures which may be performed while under the care of Dr. Dupper, and/or his staff, which may include but are not limited to medical/surgical examinations and treatments, venous ultrasound, injection sclerotherapy, superficial laser treatment, and/or local and tumescent anesthesia under the general and special instructions of the patient's physician or surgeon.

PRIVATE PAY

For patients having no insurance, or choosing not to bill their insurance, it is expected that all services will be paid in full prior to services, or they must have made suitable arrangements for payment. In all cases, accounts must be resolved in full within ninety (90) days. Accounts not resolved within ninety (90) days may be referred to an outside collection agency for further follow-up.

ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS

I, the undersigned, represent that I have insurance coverage with and do hereby authorize my insurance company to pay and assign directly to Robert L Dupper, MD, PC, d/b/a Vein Treatment Specialists, PC, all surgical and/or medical benefits, if any, otherwise payable to me for services at a rate not to exceed Vein Treatment Specialists, PC's regular charges for those services. It is agreed that payment to Vein Treatment Specialists, PC, pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. **I understand that I am financially responsible for all charges not covered by this assignment.** I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

Our clinic does not accept foreign insurance as a source of payment. These accounts will be followed as a private pay and must adhere to the guidelines set forth above in the Private Pay section.

MEDICARE PATIENT'S ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges of the physician charges for his services. I understand I am responsible for any remaining balances.

Vein Treatment Specialists, PC does accept Medicare. If you have a supplemental insurance, depending on your plan, it may cover the remaining 20% Medicare does not cover. The patient will be responsible for any balances the supplemental insurance does not cover. Patients without supplemental insurance are responsible for the remaining 20% on all services provided.

PERSONAL VALUABLES

It is understood and agreed that Vein Treatment Specialists, PC shall not be liable for the loss or damage to any money, jewelry, documents, fur garments, dentures, eye glasses, hearing aids, prosthetics, or other articles of unusual value and shall not be liable for loss or damage to any other personal property.



CONSENT TO PHOTOGRAPH / VIDEOTAPING

Vein Treatment Specialists, PC is permitted to take pictures of the medical or surgical progress involving the patient and to use same for scientific, educational or research purposes. The patient consents to photography during medical or surgical procedures and the use of same for scientific, educational or medical research purposes. The patient further consents to routine photography related to patient care.

FINANCIAL OBLIGATIONS

I understand I am responsible to Vein Treatment Specialists, PC for all charges incurred by me and not paid by third party benefits. In the event said bill, or any part thereof, is deemed delinquent by the practice, I understand I will be responsible for collection of expenses as well as reasonable attorney's fees and court costs if a suit is instituted. All delinquent accounts shall bear interest at the maximum rate allowed by law.

CANCELLING APPOINTMENTS

I understand I am responsible for notifying Vein Treatment Specialists, PC at least 24-hours before my scheduled appointment if I am unable to keep said appointment. Failure to do so may result in my account with VTS being assessed a cancellation fee of up to \$150.00.

RELEASE OF INFORMATION

Vein Treatment Specialists, PC will obtain the patient's consent and authorization to release protected health information concerning the patient, in accordance with HIPAA regulations, except in those circumstances when Vein Treatment Specialists, PC is permitted or required by law to release information. For further information, please see the attached 'Notice of Privacy Practices' at Vein Treatment Specialists, PC.

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.

Patient Signature

Date Signed