

STATEMENT OF PAYMENT TERMS

I, _____, am a patient and/or the responsible party signing on behalf of a patient of, Dr. James Robelen, and in consideration for services rendered, understand and agree to the following:

- (1) I understand and agree that I alone am responsible for any and all financial expenses incurred as a result of the service(s) provided to me while a patient of Southern Illinois Vein Center(“SIVC”). Initials:_____
- (2) I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from SIVC. Initials:_____
- (3) I will be responsible for any co-payment, deductible, or service not covered by my insurance provider. Initials:_____
- (4) I understand that any co-payment or deductible is due on the day services are rendered. Initials:_____
- (5) I hereby authorize SIVC to file with my insurance carrier, and I assign payment of medical benefits to SIVC. Initials:_____
- (6) I understand as a patient it is my responsibility to verify with my insurance company that SIVC is a member of my provider network(HMO, PPO, etc.). I understand that I am responsible for notifying SIVC of any changes in insurance coverage. Failure to notify SIVC of these changes will make me responsible for claims not accepted by the insurance company. Initials:_____

Medicare Refusal To Pay for Services/Laboratory Tests

I understand that Medicare has its own set of regulations to determine which test results they feel are appropriate for a medical condition or screening for a medical condition and base their payment on such regulations. SIVC may feel that certain diagnostic/screening procedures or laboratory tests are indicated for which Medicare will not pay. In the event that a procedure or test is ordered that is not deemed necessary by Medicare, I understand that I am responsible for such procedures or tests. Initials:_____

- (7) If I do not have insurance coverage for services rendered by SIVC, I agree to pay all charges resulting from such services. Initials:_____
- (8) I understand and agree to sign a Payment Plan Agreement evidencing my obligation and responsibility for payment for all services rendered. Initials:_____

Date

Patient or Responsible Person(s) Signature