VIC
VASCULAR INSTITUTE
Chattanooga | Cleveland
North Georgia | Jasper | Dayton

Patient Financial Guidelines Acknowledgement

Thank you for choosing Vascular Institute of Chattanooga for your health care needs. Understanding insurance, co-pay, and financial responsibility can be confusing. We hope the following information answers some of the questions you may have regarding your financial responsibility.

Arrival

Please bring the following information to help ensure proper management of your patient account.

- Health Insurance Card
- Referral - if required by your health care provider or insurance
- Address and phone numbers (day, evening, and cell)
- Payment of co-pay at the time of your appointment by cash, check, or major credit card

Insurance

To help you get the most from your health plan we encourage you to become familiar with your insurance plan's requirements before seeking care. Insurance plans have significant differences and you should know and understand your benefit package. Should you have questions, please contact your insurance company at the telephone number on your insurance card. If your insurance provider is out of network, we will provide your care; however, you will be responsible for any fees that insurance does not cover. If you have any questions, please let us know.

You will be responsible for paying any co-payment at the time of your appointment. You may also be responsible for any deductibles, co-insurance or payment for non-covered services, at the time of your appointment.

We will submit a claim to your insurance company, provided you supply all the required information. If your insurance company fails to pay within a reasonable time, you will be expected to pay for the service.

Worker's Compensation

If your health care needs are the result of an accident, please provide the following information to ensure your claim is handled in a timely manner.

- Date and type of injury
- Auto accidents require any auto insurance information including contact name, claim number, address and telephone number.

Financial Payment Plan

If you are unable to meet your financial responsibility, you may make payment arrangements by meeting with our counselors to set up a financial plan.

This acknowledgement will remain in effect for one year following date of signature.

_____ _____ _____

Signature of Patient or Personal Representative **Date** **Relationship** to Patient

_____

Printed Name of Patient or Personal Representative