GOLDMAN
VEIN INSTITUTE

3535 Military Trail
Suite 204
Jupiter, FL 33458

2515 State Road 7
Suite 210
Wellington, FL 33414

OFFICE POLICIES

We are dedicated to providing the best possible care for you, & we want you to completely understand our financial Policies.

Financial Policy

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Payment by Cash, Check, VISA, MasterCard.
2. Keep in mind your insurance policy is basically a contract between you & your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor- in other words, if you agree to have your insurance company to pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have tool to you for payment. If we later receive a check form your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept assignment of benefits. We will bill them and you are required to pay co-payment at the time of your visit.
4. If you are insured by a plan that we do not have prior arrangements with, we will prepare & send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the times of service.
5. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be “not covered” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance.
7. If all attempts on our behalf to collect a debt have not been satisfied, we will forward the account to a collection agency.

Patient Appointment Responsibilities

To ensure your quality of care and the quality of care of all other scheduled patients, we require minimum of 48 hours notification in the event that your appointment must be rescheduled. Any patient canceling an appointment without 48 hours of notice will be charged a fifty ($50.00) cancellation fee.

Consent to Treatment

As part of the course of the diagnosis and treatment of my medical condition, I voluntarily consent to the provision of all diagnostic tests, Physical examinations, medical procedures, medications and other items and services that Dr. Alexander Goldman (My Doctor) deem appropriate to diagnose and treat the conditions that I discuss with my doctor or care providers. I acknowledge that no guarantees have been made to me about the outcome of any services provided by my doctor or care providers.

I understand that violating these conditions on the Financial Policy, Cancellation Policy & Consent to treatment will result in my automatic dismissal from the practice.

Signature of Patient/ Guardian _____ Date _____