Gilvydis Vein Clinic
GENEVA • SYCAMORE • NAPERVILLE

Financial & Office Policies

Thank you for choosing Gilvydis Vein Clinic. Please understand that payment of your bill is part of your treatment and care. For your convenience, we have answered a few commonly asked financial and office policy questions below.

Cancellation/No Show Policy

It is expected that I show up for my scheduled appointment on time. I understand that if I show up late for my appointment that I may be required to reschedule for another day. I understand that I need to notify the office within 48 hours of a scheduled procedure. In the event of an emergency where prior notice cannot be given, the practice will give consideration.

What Is My Financial Responsibility for Services?

You will be financially responsible for all copays, coinsurance and deductibles at the time of service, depending on the type of insurance plan you have. If you do not have insurance, payment in full is due at the time of service unless prior payment arrangements have been discussed with our office. We accept payment by Cash, Check, VISA, MasterCard, Discover and American Express. It is your responsibility to know what is covered by your insurance plan and you will be responsible for the balance your insurance does not cover. We encourage you to contact your insurance company for an estimate of costs.

What if my account becomes delinquent?

Patients will be sent a monthly statement detailing any amount owed to Gilvydis Vein Clinic. Please make sure that our office staff has your current mailing address. If our office receives no payment for 2 consecutive months then your remaining balance will be due in full.

A parent or legal guardian must accompany patients who are minors during their visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

Please feel free to contact us with any questions or concerns at 815-981-4742

Please initial each of the policies listed below:

____ *I have read, understand, and agree to the above Financial and Office Policy and I understand that charges not covered by my insurance company, as well as applicable copayments, coinsurance and deductibles, are my responsibility.*

____ *I authorize my insurance benefits be paid directly to Gilvydis Vein Clinic*

____ *I authorize Gilvydis Vein Clinic to release pertinent medical information to my insurance company when requested, or to facilitate the payment of a claim.*

____ *I Understand that this is* ***NOT*** *a free screening*

By Signing below, I acknowledge that I have read, understand and accept the policies above.

Patient or responsible party:

______________________	____________________________	__________
Printed Name	Signature	Date

Witness:

______________________	____________________________	__________
Printed Name	Signature	Date