Madison Vein Center **Dr. Bailey**
Shoals Vein Center **Dr. Collignon**
A Division of Shoals Surgical Group, LLC

Patient's Name_____

Assignments of Benefits

I AUTHORIZE Shoals Surgical Group, LLC to perform medical treatment. I certify that the signature below shall serve as **Signature on File** for Medicare, Medicaid, and all insurance companies for claims filed on my behalf by Shoals Surgical Group, LLC. I assign the benefit payable for physician services to Shoals Surgical Group, LLC and authorize Shoals Surgical Group, LLC to submit a claim to Medicare, Medicaid, and all insurance companies for payment.

I understand that by signing this agreement, I am authorizing the provision of therapy for varicose veins which may include the following; Consultation, VNUS® ClosureFast® procedure, Ambulatory Phlebectomy, Sclerotherapy (non cosmetic), and Venous Duplex Ultrasound while under the care and supervision of my attending physician.

I authorize direct payment of any insurance benefits for Consultation, VNUS® ClosureFast® procedure, Ambulatory Phlebectomy, Sclerotherapy (non cosmetic), and Venous Duplex Ultrasound, to be made directly to Shoals Surgical Group, LLC, their billing agent, or to any provider of these services. I also authorize my insurance company to furnish to Shoals Surgical Group, LLC any and all information pertaining to my insurance benefits and status of claims submitted for therapy rendered.

Agreement to Pay

Madison Vein Center and Shoals Vein Center, a division of Shoals Surgical Group, LLC participates with many insurance plans as a convenience to our patients. Your co-payment and / or deductibles are determined by your insurance company. We are required to collect these fees, to ensure the insurance policy is enforced. Please understand that payment of your bill is considered in part the responsibility of the patient. Payment, according to the policies below, is due at the time of service. We accept cash, checks, MasterCard or VISA. "Bounced Checks" **will be charged a** $30.00 fee **and if not paid within 10 days will be referred to Colbert County Court or Madison County Court for Legal Action-** it is your responsibility to contact us as soon as you are aware that your check has been rejected for payment. **Also if you write a bad check you will be required to pay via cash or credit card.** All co-pays and / or deductibles, and services not covered by insurance will be collected up front on the day services are rendered.

I acknowledge that reasonable efforts will be made to have my insurance pay for this therapy. In the event that my insurance will not cover this therapy, I agree to be responsible for the full amount of the charges or any remaining balances due after insurance has paid, including any costs or expenses incurred, including a reasonable attorney's fee in collecting such payment.

I consent to the release of my medical information to any insurance company for use in determining payment for VNUS® ClosureFast® procedure, Ambulatory Phlebectomy, Sclerotherapy (non cosmetic), and Venous Duplex Ultrasound. This consent shall be valid for whatever period of time is reasonable, necessary, or until I revoke this consent in writing.

PATIENT WITHOUT INSURANCE: Payment in full is due at the time of service. We will not do any procedures/surgeries without having full payment.

Sclerotherapy and VeinWave, (treatment of spider veins) that is cosmetic is not covered by insurance companies and a claim will not be file with your insurance company. Payment in full will be collected prior to any treatment being rendered.

The undersigned certifies the following: that the foregoing text has been read, and that the undersigned is the patient or a duly authorized representative of the patient and as such as is responsible to execute the above and accept its items.

_____ _____
Patient's Signature Date