

**CONDITIONS OF SERVICE**

Thank you for choosing Hogue Vein Institute – The Regional Leader in Vein Care. This document represents our established *Conditions of Service* that will be used to resolve any issues or disputes pertaining to vein care services rendered by Hogue Vein Institute physicians and staff.

**CONSENT TO TREATMENT**

The patient identified below consents to therapeutic vein care evaluations and treatments which may be performed or assisted by HVI vein specialists while under the care of either Dr. Carl Dando, Dr. Karl Elser, Dr. Mark Hagberg, Dr. Lornell Hansen, Dr. Roger Hogue, Dr. Ron Kolegraff and/or their staff. These evaluations and treatments may include, but are not limited to, initial evaluation or consultation, history & physical examination, lower extremity venous ultrasound study, infiltration of tumescent local anesthesia, endovenous laser ablation (EVLA), endovenous chemical ablation (EVCA), ultrasound-guided sclerotherapy, vein light sclerotherapy, and/or conservative vein therapy.

**PRIVATE PAY**

For patients having no insurance, or choosing not to bill their insurance, it is expected that all vein care services will be paid in full prior to services, or at the time of service if arrangements for payment have been made acceptable to Hogue Vein Institute. In all cases, accounts must be resolved in full within ninety (90) days. Accounts not resolved within ninety (90) days will be referred to an outside collection agency.

**ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS**

I, the undersigned, represent that I have insurance coverage with, and do hereby authorize my insurance company to pay and assign directly to Roger S. Hogue, MD PA, d/b/a Hogue Vein Institute, all surgical and/or medical benefits, if any, otherwise payable to me for services at a rate not to exceed Hogue Vein Institute's regular charges for those services. It is agreed that payment to Hogue Vein Institute pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. I understand that I am financially responsible for all charges not covered by this assignment. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

Our clinic does not accept foreign insurance as a source of payment. These types of accounts will be categorized by Hogue Vein Institute as Private Pay, and must adhere to the guidelines set forth above in the Private Pay section.

**MEDICARE PATIENT'S ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges of the physician charges for his services. I understand I am responsible for any remaining balances.

Hogue Vein Institute does accept Medicare. If you have a supplemental insurance, depending on your plan, they may cover the remaining 20% that Medicare does not cover. You will be responsible for any balances that the supplemental insurance does not cover. If you do not have supplemental insurance, you are responsible for the remaining 20% on all services provided.

**CONDITIONS OF SERVICE*****PERSONAL VALUABLES***

It is understood and agreed that Hogue Vein Institute shall not be liable for the loss or damage to any money, jewelry, documents, fur garments, dentures, eye glasses, hearing aids, prosthetics, or other articles of unusual value and small size. Also, Hogue Vein Institute shall not be liable for loss or damage to any other personal property.

***CONSENT TO PHOTOGRAPH / VIDEOTAPING***

Hogue Vein Institute is permitted to take pictures of the medical or surgical progress involving vein care. The patient consents to photography and/or videotaping during medical or surgical procedures and the use of same for scientific, educational or medical research purposes. The patient further consents to routine photo-documentation related to patient care.

***FINANCIAL OBLIGATIONS***

I understand that I am responsible to Hogue Vein Institute for all charges incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by the practice, I understand that I will be responsible for collection of expenses as well as reasonable attorney's fees and court costs if a suit is instituted. All delinquent accounts shall bear interest at the maximum rate allowed by law.

***CANCELLING APPOINTMENTS***

I understand that I am responsible for notifying Hogue Vein Institute at least 24-hours before my scheduled appointment if I am unable to keep said appointment. Failure to do so may result in my account with Hogue Vein Institute being assessed a \$100 cancellation fee.

***RELEASE OF INFORMATION***

Hogue Vein Institute will obtain the patient's consent and authorization to release protected health information concerning the patient, in accordance with HIPAA regulations, except in those circumstances when Hogue Vein Institute is permitted or required by law to release information. For further info, please see the 'Notice of Privacy Practices' at Hogue Vein Institute.

***SEVERABILITY***

If any terms or conditions of this agreement are held by a court of law to be invalid or unenforceable, then this agreement, including all of the remaining terms and conditions, will remain in full force and effect as if such invalid or unenforceable term or condition had never been included. My signature below acknowledges that I have received a copy of this document and accept its terms.

Patient or Responsible Party Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date Signed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_