

SYNERGY HEALTH CONCEPTS, INC.

Michael Arata, MD • Todd S. Harris, MD • Nina Grewal, MD • J. Joseph Hewett, MD

Board-Certified Physicians in Interventional Radiology, Vascular Surgery, General Surgery and Phlebology

Statement of Patient Financial Responsibility

Thank you for choosing Synergy Health Concepts, Inc. as your healthcare provider. We are committed in providing you with the highest quality healthcare. We ask that you read, initial, and sign this form to acknowledge your understanding of our patient financial policies.

The purpose of this form is to help you make an informed choice about whether or not you want to receive the medical services listed below, as they may not be covered by your insurance policy. As a provider we must inform you of our services and the exact costs associated with them. Our office does not obtain prior authorization from your insurance for any of our services; however, we can provide you with information after your procedure if you wish to submit a claim to your insurance carrier independently.

In the event that your insurance company does not agree to pay for the services that were authorized and performed, or in the event that services are deemed not medically necessary, by signing this Financial Liability Waiver, you are agreeing to take financial responsibility for the services rendered.

Based on your prescribed treatment, listed below are the costs for which you are responsible:

Procedure: Venogram and Angioplasty **Cost:** \$8,000
(Patients with no previous procedures)

Procedure: Repeat procedure **Cost:** \$8,000
(Patients with previous procedure not with Synergy, no stents)

Procedure: Repeat procedure **Cost:** \$6,000
(Patients with previous procedure with Synergy)

As Venous Specialists, the Physicians at Synergy Health Concepts provide the highest level of service to our patients. Therefore, patients which have had previous stents placed may require additional equipment, medications, and materials for proper treatment. These often require prior notification so that appropriate supplies are available for each patient. Additionally, some patients may require an overnight stay at our surgery center to complete their treatment. To provide patients with the highest quality care, the cost associated with these treatments exceeds that of a standard procedure. Due to these factors, below are the costs for which you are responsible:

Procedure: Repeat procedure **Cost:** \$12,000
(Patients with previously placed stents)

Procedure: Repeat procedure **Cost:** \$18,000
(Patients with previously placed stents, with clot/thrombus)

Pt Initials: _____

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During your procedure, your Physician may decide that stent placement(s) is required. This may be due a number of medical indications including, but not limited to, a blockage within your vein, a tear inside your vein, or for other syndromes diagnosed during your procedure such as May Thurner disease. The cost of stent placement(s) is not included in the procedure costs listed above. If your Physician places a stent for any reason, below are the costs for which you are responsible:

Procedure: Stent placement **Cost:** \$2,000
(Inclusive of all stents placed, this is not per stent)

Pt Initials: _____

By signing this form, you understand that all of the above charges are collected for the procedure being performed. However, successful outcomes including, but not limited to, completely treating all blockages, opening previously placed stents, or removing all clot from previously placed stents which are occluded, is not guaranteed. Under no circumstances is the patient entitled to refunds or discounts due to sub-optimal results. These charges are made without any guarantees to their outcome, written or implied.

The fees for your procedure will be collected from you prior to your procedure. However, the additional costs for stent placement(s) will be charged to your method of payment after the procedure. Additionally, if stents from a previous procedure are not documented, but are found during your procedure, or if clot is found within previously placed stents, additional charges as outlined above will apply to your case. By signing this form, you understand that additional charges may be incurred during your procedure and you are providing authorization for those charges.

Your signature verifies that you have read the above statement, understand your responsibility, and agree to the terms.

Patient's Name: (Please Print) _____

Patient's Signature: _____ **Date:** _____