Financial Responsibility

SYNERGY HEALTH

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

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Synergy Health Concepts, PC 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.

For all patients, please review the complete listing of our fees and our required payment schedules. For insured patients, 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:

Imaging:	Dr. Haacke Protocol MRI/MRV of Head, Neck, Chest	**Cost:** $2,500
Procedure:	Venogram and Angioplasty	**Cost:** $8,000
Procedure:	Repeat procedure *(Patients with previous procedure not with Synergy)*	**Cost:** $8,000
Procedure:	Repeat procedure *(Patients with previous procedure with Synergy)*	**Cost:** $6,000

Pt Initials: _____

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

Pt Initials: _____

The above costs include all the expenses you are responsible for in association with your procedure. Below is a breakdown of these charges and when they are due.

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Deposit

A $1000 deposit is required on the day your procedure date is confirmed. This is for the benefit of all of our patients and helps avoid cancellations and delays in other patients' care. This deposit is NON-REFUNDABLE under any circumstances but can be transferred to another day if you need to change your appointment date.

If you are using your insurance to help pay for your CCSVI procedure, your deposit allows our office to initiate the process of obtaining prior authorization from your insurance carrier. The duration of this process is dependant on several factors many of which are intrinsic to your insurance carrier.

Due to the amount of time our office invests in obtaining authorizations for your procedure, this deposit is NON-REFUNDABLE under any circumstances. These include delays in obtaining your authorization, a denial of coverage, or a denial of authorization. If your insurance carrier denies your coverage or your authorization, you are encouraged to apply this deposit to the cash price for the procedure.

Deposit: Required upon confirmation of procedure or for initiation of insurance authorization

Cost: $1,000

Pt Initials: _____

Procedure Fees

Final payment for the CCSVI procedure is due before the procedure. This payment can be made prior to your arrival in California or at the time of your consultation.

For those patients not paying with insurance, the balance of the procedure fee and any applicable imaging fees are required.

For insured patients, please realize that insurance carriers vary widely on reimbursement for this procedure and on how quickly this payment is processed. Due to this fact, an additional $4000 *insurance deposit* is required prior to the CCSVI procedure. After your procedure, Synergy will assist you in submitting all the necessary paperwork to your insurance carrier for reimbursement on your behalf. **All subsequent payments from your insurance carrier will be made directly to you as reimbursement for your procedure.**

Imaging Fee: Dr. Haacke MRI/MRV

Cost: $2,500

Pt Initials: _____

Procedure Fee: Non-insured patients

Cost: $7,000

Pt Initials: _____

Procedure Deposit: Insured patients

Cost: $4,000

Pt Initials: _____

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Out of Pocket Expenses (Insurance Patients Only)

Most insurance policies require out of pocket expenses of varied amount ranging from 10% to 50% (80%:20%, 70%:30%, etc). As your health care provider, we will inform you of your out of pocket expenses and your deductibles associated with Synergy Health Concepts charges. Any payments to Synergy required by your insurance carrier will be refunded to you directly from your deposit: **you will not be responsible for these charges.**

However, there will be charges submitted to your insurance carrier from the hospital or surgery center where your procedure is performed. **These charges are not associated with Synergy or our Physicians and may require co-pays that are outside the control of Synergy Health Concepts.**

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. By signing this form, you understand that additional charges may be incurred during your procedure and you are providing authorization for those charges.

For insured patients, our office will have obtained a prior authorization and/or pre-determination from your insurance carrier for our services. However, this is still not a guarantee that your insurer will reimburse you and/or Synergy for these medical services. Your signature verifies that you have read the above statement(s), understand your responsibility, and agree to these terms.

Patient's Name: *(Please Print)* _____

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

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