Patient Label

Estimate Agreement

Vincent Vein Center staff may offer, upon request, an estimate of out-of-pocket costs for treatment. Providing you with an estimate of your potential costs is an imperfect process and although we would like to guarantee our pricing estimates, it would be inappropriate to do so. Any estimate offered is provided with the understanding that it is not a contract for the actual amount patients will be required to pay. You will be held responsible for the actual amount you owe, which is typically determined after services are rendered.

An estimate is our educated guess at what a service may cost - it isn't binding and is subject to change. Estimates provided by Vincent Vein Center cannot and should not be relied upon as the actual charges and/or payments you will be responsible for paying, as the actual charges and/or payments may be either lower or higher than the estimate depending on a number of variables. All estimates are based in part on information provided to us by third parties, and we cannot account for errors made by other parties. Additionally, we cannot predict or estimate for changes in treatment decisions, unforeseen complications, additional tests or procedures ordered by a physician, and your particular health care needs. The estimated patient cost may not include pre-procedure office visits, post-procedure office visits that are not a part of routine care, or diagnostic testing.

Patients with insurance should also contact their health benefits administrator or insurance carrier for the most accurate information regarding plan structure, deductibles, co-payments, coinsurance, and any other factors that might affect your personal liability for anticipated health care services. If you have met all or part of your deductible or maximum out-of-pocket expenses, the actual amount you owe may be different. Please note that information given to us by your insurance company regarding your policy should not be interpreted as a guarantee of insurance coverage or an agreement to pay on claims. Please check with your insurance company if you need help understanding your benefits for the service chosen.

I HAVE READ AND UNDERSTAND THE ABOVE DISCLAIMER AGREEMENT AND I FULLY UNDERSTAND THAT ANY INFORMATION PROVIDED TO ME BY VINCENT VEIN CENTER REGARDING CHARGES, BILLED AMOUNTS, OR POTENTIAL COSTS ARE ESTIMATES ONLY. THE ACTUAL AMOUNT I WILL BE REQUIRED TO PAY MAY BE, AND LIKELY WILL BE, DIFFERENT (HIGHER OR LOWER) THAN THE ESTIMATED AMOUNT.

_____ _____

Print Patient Name Date of Birth

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient Representative Relationship to Patient

(Required if the patient is a minor or dependent adult)