PATIENT CONSENTS

Lake Washington Vascular, 1135 116th Ave NE, Suite 305, Bellevue, WA 98004 | Phone: (425)453-1772 | Fax: (425) 453-0603

Please take a moment to read this information thoroughly.

Consent to Photograph

I understand that insurance carriers may require my medical photos to authorize procedures or payments to Lake Washington Vascular. Your name will be attached to your claim.

Initials:________

I hereby grant consent to Lake Washington Vascular to use my medical photographs for the following designated purposes:

- Educational material for medical professionals and patients
- Marketing communications and promotional resources

I reserve the right to revoke this consent at any time with written notice.

☐ I will not allow

☐ I will allow

Consent to Contact for Research

Lake Washington Vascular engages in clinical research to improve vascular treatments. May we contact you about participating in a trial if you are eligible?

☐ Yes

☐ No

Initials:________

I understand that this information will be retained in my Medical Record and I agree to inform Lake Washington Vascular of any changes to these authorizations and consents.

Lake Washington Vascular is permitted to utilize de-identified patient data (stripped of names and personal identifiers) to enhance quality care and research database objectives.

Initials:________

Consent for Prescription History Inquiries

I hereby authorize Lake Washington Vascular to access my prescription history for up to one year from pharmacy benefit managers, insurers, and pharmacies. This history may be obtained upon scheduling an appointment, any change in appointment status, or when a prescription is issued on my behalf.

Initials:________

Assignment of Benefits

I, the undersigned, give consent to Lake Washington Vascular, PLLC, and its providers to render the professional services to the patient identified herein.

I, the undersigned, acknowledge receiving and reading a copy of the Payment Policy for Lake Washington Vascular, PLLC. I assume full responsibility for payment of this account, including fees assessed for missed appointments. I recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any disputed claim settlement. In the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, I agree to pay an additional charge equal to the cost of collection, including agency and attorney fees, and court costs; incurred and permitted by the laws governing these transactions, no less than 35% of the principal amount. A finance charge of 18% APR may be charged on all balances over 30 days, regardless of pending insurance claims.

I assign all insurance benefits for treatment to be paid directly to Lake Washington Vascular, PLLC, and request that this assignment remains on file with my insurance carrier.

Initials:________

PAYMENT POLICY

Lake Washington Vascular, 1135 116th Ave NE, Suite 305, Bellevue, WA 98004 | Phone: (425)453-1772 | Fax: (425) 453-0603

Please take a moment to read this information thoroughly.

We at Lake Washington Vascular are sensitive to the ever-increasing cost of health care. For this reason, each of our providers is dedicated to rendering only those professional services that are deemed necessary and appropriate. To assist us in controlling the costs associated with these services, we have implemented the following payment policy. We encourage you to retain this copy of our payment policy for your records.

Fees

Lake Washington Vascular offers a broad range of diagnostic and interventional services. Each of these is billed separately. The fee for a particular service is available upon request.

Additional fees may be assessed for returned checks and copies of medical records.

Payment at the Time of Service

Patients without insurance coverage are required to make a payment at the time of service.

Patients with insurance are expected to pay their co-payment or other co-insurance at the time of service.

Insurance

We bill insurance carriers as a courtesy to our patients. This requires that we have the signature of the patient and/or guarantor on file. We may attempt to verify insurance benefits in advance; however, this is not a confirmation or guarantee of insurance coverage or payment. Thirty days are allowed for insurance claims to be processed, after which the patient is held responsible for payment. Resolution of coverage disputes with an insurance company is the responsibility of the policyholder. We will not bill insurance plans for which the patient is not a subscriber or a member.

Billing

Insurance claims are prepared and submitted on a regular basis. Statements are prepared and mailed to patients every 30 days. These statements provide an itemization of all account activity. Account balances older than 30 days may be subject to a finance charge of 18% APR. Accounts declared delinquent may also be subject to collection and legal fees of no less than 35% of the principal amount.

Missed Appointments

A penalty fee for missed or canceled appointments with less than 48 business hours notice may be incurred. This policy helps us maintain a timely and efficient schedule, ensuring all our patients receive the best possible care.

Exceptions

Requests for exceptions to this payment policy are reviewed on a case-by-case basis. When payment by installment is deemed necessary, a written agreement will be drafted by the Patient Account Representative and signed by the responsible party(ies).