The Vein Center of Excellence in the treatment of vein disorders

Lori L. Greenwald, MD, FACS
Medical Director

Authorization of payment, Release of Information and Financial responsibility of the patient

1) I hereby authorize direct payment of medical benefits to Lori L. Greenwald, MD PC otherwise payable to me.
2) I understand that I am financially responsible for all remaining balances including but not limited to insurance copayments, coinsurance amounts, deductibles, and any non-covered services as determined by my individual health insurance policy.
3) I understand that it is my responsibility to know the details of my individual health insurance plan which includes but is not limited to referrals, exclusions, deductibles, coinsurances, copayments pertaining to but not limited to all consultations including spider vein consultations, office visits, ultrasounds, and any and all treatments provided by Vanishing Veins. Insurance benefits and insurance exclusions are always subject to change and this is not always something we are able to know in advance.
4) I understand that when a service is covered by my insurance carrier; my insurance carrier will not pay for any balances arising from my deductible, copayments, coinsurance and any other balance owed the medical provider as determined by my health insurance policy. All of these balances are my financial responsibility as the insured.
5) If my insurance denies a claim submitted on my behalf, I understand that I am responsible for the payment as dictated by the terms of my individual health insurance policy and the contract that I have made with them. A denial is solely at the discretion of an insurance carrier and is issued by that insurance carrier based on their specific guidelines and criteria. The clinical provider of service and/or facility is not part of this denial process.
6) I further authorize Vanishing Veins to release information requested by my insurance carrier to support payment of my claim.
7) By signing this document I assume full financial responsibility for all payment and outstanding balances as described above.
8) Services will not be provided if there is an outstanding balance unless arrangements have been made in advance with the business department. Vanishing Veins accepts VISA, MasterCard, Discover and personal checks.

Patient Name: ____
(Please Print)

Patient Signature: ____

Date: ____________________

Medicare Patients

I request payment of authorized Medicare benefits be paid on my behalf directly to Lori L. Greenwald, MD PC for medical services provided to me. I authorize Dr. Greenwald and Vanishing Veins to release any healthcare information required by the Health Care Financing Administration and its agents to determine benefit payment for medical services provided.

Patient Name: ____
(Please Print)

Patient Signature: ____

Date: ____________________

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Rev. 08.07.2013 LLG