Vein Center For Women P.C.

(DBA: Absolute Vein Care)

Dear Patient:

- All Co pays are due at the time of service. Please ensure you have a valid referral at the time of your visit as per the directive of your insurance company.
- If you have been given a prescription to have any lab work done, please make sure you go to the lab that your insurance company has contracted with
- Please call our office for the results of your lab work within a week after you have them done
- You will be set up for a follow up appointment in our office to discuss all results: especially diagnostic ultrasound, CT scans, X-rays etc; I do not discuss results over the telephone to ensure patient privacy.
- In the interest of disseminating accurate information about your medical condition, my staff is not authorized to discuss reports over the phone with you except under my special directives
- My office needs at least 48 hours notice for all CT scan pre-authorizations. Kindly make your appointment with the radiology services after this period.

Thank you,

Girija S. Surya, M.D. (*Board Certified in Cardiovascular and Thoracic Surgery*)
Vein Center For Women, P.C.

Patient Consent

A. I certify that I, _____ and / or my dependent(s), have insurance coverage. My insurance is with _____ ***(Name of Primary Insurance Company)*** (and with) _____ (Secondary insurance, if any) and (ii) I assign directly to **Vein Center For Women P.C. (also DBA Absolute Vein Care)** all insurance benefits, if any, otherwise payable to me for services rendered.

I authorize the use of my signature on all insurance submissions.

The above named company / physician may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

OR

B. I, _____, have no insurance coverage and I am a self-pay.

I understand that I am financially responsible for all charges incurred, whether or not (i) I have insurance or (ii) paid by insurance.

This consent will end (i) one year from when my current treatment plan is completed and / or (ii) all payments due have been paid or satisfied.

A copy of this notice will be provided to me if I so desire.

I have read and understood these directives.

Signature: X _____ Print Name: _____

Date: _____

670 North Beers St.
"Colonial Commons"
Bldg. 2, Ste. 4
Holmdel, NJ – 07733 - 1527

646 Rte. 18
"Plaza Hill"
Bldg. A Ste. 103
East Brunswick, NJ - 08816 - 3722

Ph: (732) 254-0500 E-Mail: Contact@VeinCenterForWomen.com Fax: (732) 254-1558
WWW.VeinCenterForWomen.com

VEIN CENTER FOR WOMEN

AGREEMENTS & AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby authorize and consent to treatment provided by ***Vein Center For Women***, employees or designees and authorize medical services, diagnostic procedures and medication as necessary or advisable by the caregiver(s) providing treatment. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications which may be given to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ***Vein Center For Women*** to release information required in the processing of application for financial coverage for services rendered. This authorization provides that my physician or my physician's staff may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent to evaluate my claims or its liability under such policies or contracts or coordination of benefits pursuant to such policy or contract provisions. The information obtained will be treated as privileged and confidential and will not be released to any person without my expressed or written consent. Correspondence and test results will only be released to physicians involved in my case.

ASSIGNMENT OF INSURANCE BENEFITS/REFERRALS/PAYMENTS GUARANTEE/COLLECTION FEE/NSF FEE

I hereby authorize payment to be made directly to ***Vein Center For Women*** for insurance benefits payable to me. I understand that I am financially responsible to ***Vein Center For Women*** for any covered or non-covered services, as defined by my insurer, which are not paid by my insurer. I understand that I am financially responsible for payment in full if no required referral is received by this office. I understand that I am financially responsible for any collection fee and any reasonable attorney's fees and other costs incurred for collection including, but not limited to 1 ½ % interest per month on any outstanding amounts unpaid 90 days after insurance resolution. I understand that I am financially responsible for a returned check for any reason and a $35.00 NSF fee.

PAYMENT POLICY

The patient (or adult/guardian who brings in minor patient) will be responsible for all copayments and deductibles. ***Vein Center For Women*** does not forward bills to other parties regardless of court rulings or divorce decrees.

MISSED APPOINTMENTS

I understand that in order for ***Vein Center For Women*** to best serve their patients, they ask for at least 24 hours' notice if I am unable to keep an appointment. This allows them to try to fill my scheduled appointment time with another patient. If they do not receive this notice, I will be charged a missed appointment fee of $85.00. My signature below signifies acceptance of the Missed Appointments terms.

IF MY INSURNACE CHANGES OR I HAVE NO CURRENT INSURANCE CARD AT THE TIME OF SERVICE

If I do not present my current insurance card for any date of service, I will be billed as a self-paying patient. ***Vein Center For Women*** may not be able to back date from the time of service to when I do present a valid insurance card. I may be asked to seek reimbursement from my insurance carrier(s).

MEDICARE

Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information that is needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to ***Vein Center For Women***.

HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I was offered and/or received the physician's HIPAA Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential information. I understand that ***Vein Center For Women*** has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me upon request.

PATIENT ACKNOWLEDGEMENT

I have read the Agreements & Authorizations form. I understand its contents, and that I have had an opportunity to discuss its contents with ***Vein Center For Women*** to my satisfaction. I understand that my signature represents agreement with the contents of the forms and that any statement may not amend the contents of the form. I understand that the records/information released will not be further disclosed for any purpose other than stated in this Authorization.

Patient Name (PRINT)	Date
X Patient or Authorized Representative Signature	Relationship (if other than Patient)
Patient unable to sign: Verbal consent given to staff	Reason

Vein Center For Women P.C.
(DBA: Absolute Vein Care)
Girija S. Surya, M.D. *(Board Certified in Cardiovascular and Thoracic Surgery)*

Authorization to Release Medical Records

To: _____
(Physicians Name)

_____
(Address)

_____
(City) (State) (Zip code)

I REQUEST THAT ALL MY MEDICAL RECORDS, INCLUDING LABORATORY REPORTS AND X-RAY REPORTS BE RELEASED TO:

Vein Center for Women P.C.

Glirija Surya, M.D.
646 RT 18, Bldg A Suite #103
New Jersey 08816
Ph: (732) 254-0500
Fax: (732) 254-1558

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Patient Signature: X_____ **Date:** _____