ALL PATIENTS

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.

I hereby authorize direct payment of medical and/or surgical benefits, including major medical benefits to which I am entitled, Medicare, Private Insurance, and any other health plan to **Delaware Valley Vein Centers/Associated Vein Solutions.**

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect unless revoked by me in writing.

I understand that as these services were performed for me or my legal dependent, I am financially responsible for any charges whether or not paid by insurance.

Print Form to Sign and Date

_____ _____

Signature of patient or responsible party Date

MEDICARE PATIENTS

I request that payment of authorized Medicare/Medigap benefits be made on my behalf to **Associated Vein Solutions** for any services furnished me by **Associated Vein Solutions**. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Print Form to Sign and Date

_____ _____

Signature of patient or responsible party Date

MEDICARE # _____ MEDIGAP PLAN _____ MEDIGAP PLAN ID _____

In Compliance with Medicare regulations we are required to ask the following questions:

Do you or your spouse work for a company that provides you with health insurance?	Yes ☐	No ☐
Are you entitled to Medicare because of disability or End Stage Renal Disease?	Yes ☐	No ☐
Is the illness or injury the result of an automobile accident or other injury?	Yes ☐	No ☐
Has treatment for the accident or illness been authorized by the Veteran's Administration?	Yes ☐	No ☐
Are you entitled to any benefits under the Federal Black Lung Program?	Yes ☐	No ☐

I certify that this information is true and complete to the best of my knowledge

Print Form to Sign and Date

_____ _____

Signature of patient or responsible party Date

Clear Form

FOR OFFICE USE: If all questions are answered "No" Medicare is the primary payer. If *any* of these questions are answered "Yes", Medicare may be secondary. VERIFY!

Print