THE VEIN AND LASER CENTER
OF NORTHERN COLORADO

CONSENT TO TREATMENT

I am a patient at The Vein and Laser Center of Northern Colorado (VCNC). By signing this form, I give my consent to be treated by the doctors of this practice.

RELEASE OF HEALTH INFORMATION

VCNC may release my health information to other doctors and staff who treat me. VCNC may release my health information to insurance companies. VCNC may release my health information to companies that help improve the quality and cost of care provided to patients by reviewing the health care provided by this practice. **I hereby authorize VCNC to speak to the individuals named below regarding my care, test results, and my bill:**

_____

Name phone relationship to patient

_____

Name phone relationship to patient

_____ **I DO NOT** want my information given to family or friends

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices tells me my rights as a patient at VCNC. This includes how my medical records are protected by VCNC. This notice is posted in the waiting area at VCNC. Upon request, I may receive a printed copy of the notice.

FINANCIAL POLICIES

I hereby assign all medical and/or surgical benefits, to include all major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan, to The Vein and Laser Center of Northern Colorado. A photocopy of this assignment is to be considered as valid as an original.

- I am responsible for providing proof of insurance coverage and will inform VCNC of any changes to my insurance or demographic information.
- Regardless of insurance coverage, all charges are ultimately my financial responsibility.
- If my insurance requires a referral from my PCP to be seen at VCNC, it is my responsibility to see that this is completed. I am fully responsible for all charges not covered if a referral was not obtained.
- Co-pays are due at the time of service.
- It is my responsibility to understand my insurance benefits such as co-pays, deductibles, and co-insurance. I understand I may be required to pay an estimated patient portion of my charges on the day of my procedure.
- If I do not have insurance, payment is due at the time of service unless other arrangements have been approved by the office manager.
- If a payment arrangement is made on a balance due, I understand I must comply with that arrangement until the balance is paid in full. If my account becomes past due, VCNC may initiate the collection process.

PATIENT ACKNOWLEDGEMENT

I attest, with my signature below, that:

- The information I have given VCNC is correct
- I have read and understand all the information stated above
- I have had a chance to ask questions about this information and my questions have been answered
- I may withdraw this form at any time with a written request to VCNC

_____

Printed patient name Signature of responsible party Date

www.ColoradoVeinAndLaser.com

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