TOTAL VEIN CONCEPTS

Greenbrier Healthplex
713 Volvo Parkway, Suite 105 ♦ Chesapeake, Virginia 23320
Phone (757) 282-4045 ♦ Fax (757) 282-4030

Patient Waiver/Consent and Agreement to Pay Form

I understand that by signing this agreement, I am authorizing Dr. ___________________ to perform the treatment/procedure(s) for my medical condition. Dr. ________________ has thoroughly explained the alternative treatments available to treat my medical condition. The known risks have been explained and I am fully aware of the risks involved in the treatment procedure. I am also aware there are risks accompanying any surgical procedure and there is no guarantee on the results of the surgery, as well as, freedom from potential complications.

I acknowledge that every billing effort will be made to my insurer for the reimbursement of the procedure and in the event of insurance denial to pay I agree to be responsible for the full amount of the billed charges or the remaining balance after my insurer has paid.

> **Insurance Authorization**: I request that the payment of authorized benefits be made to Medical Center Radiologists on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to any insurance company responsible of paying such benefits; any information needed to determine these benefits for related services.

I give valid consent of the release of all medical record documentation to any insurance company for determination of reimbursement for the treatment procedure. I also authorize all benefit information pertaining to my insurance be released to help in the reimbursement process. My consent is valid for whatever time frame necessary until further notice.

> **Release of Medical Record**: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

I have read, understand and have a copy of the Waiver/Consent and Agreement to Pay Form and accept all terms listed above.

Patient's Signature ________________________________ Date _____________

Parent or Legal Guardian Signature ____