AGREEMENTS & AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby authorize and consent to treatment provided by ***Siragusa Vein and Laser***, 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 ***Siragusa Vein and Laser*** 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 ***Siragusa Vein and Laser*** for insurance benefits payable to me. I understand I am financially responsible to ***Siragusa Vein and Laser*** for 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 any required referrals are not received by this office

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 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 ***Siragusa Vein and Laser***.

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 ***Siragusa Vein and Laser*** 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 ***Siragusa Vein and Laser*** 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
______________________________	______________________________
Patient or Authorized Representative Signature	Relationship (if other than Patient)
______________________________	______________________________