GRAND VEIN SPECIALISTS

Ever Clinic

PATIENT RESPONSIBILITY FORM

Thank you for choosing Grand Vein Specialists, Ever Clinic as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read this form to acknowledge your understanding of our patient financial policies.

Patients Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her/his treatment and care.
- We are pleased to assist you by billing for our insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays. Coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Grand Vein Specialists Ever Clinic. These charges may include but are not limited to:
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    - Charge for returned checks
    - Charge for missed appointments without 24 hours notice.
    - Charges for the copying and distribution of patient medical records.

Patient Authorization

- By my signature below, I hereby authorize Grand Vein Specialists Ever Clinic and the physicians, staff and hospitals associated with Grand Vein Specialists to release medical and other information acquired in the course of my examination and/or treatment (with the stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to Grand Vein Specialists, Ever Clinic and any associated healthcare entities for the services rendered as allowable under standard third party contracts. I understand that I am financially responsible for the charges not covered by this assignment.
- By my signature below , I authorize Grand Vein Specialists, Ever Clinic personnel to communicate by mail, answering machine, and/or email according to the information I have provided in my registration information.

I have read, understood and agree to the provisions of this Patient Financial Responsibility Form.

_____ _____

Signature of Patient or Guardian Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____ _____

Signature of Patient of Guardian Date

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Berwyn IL 60402

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