ESPINOZA
VEIN INSTITUTE
HEALTHY LEGS A STEP AWAY

PATIENT AGREEMENT

PLEASE INITIAL NEXT TO EACH PARAGRAPH. YOUR INITIAL IS AN AGREEMENT WITH THE OUTLINED TERMS AND CONDITIONS.

a) **Authorization to Release Information:** I hereby authorize EVI to send my insurance carrier or sponsoring agency or to the Social Security Administration or its intermediaries or carriers, when relevant, any relevant medical information that is requested by them for the processing of insurance claim benefits. ☐

b) **Authorization to leave voice messages**: I hereby authorize EVI to leave voice messages on the primary telephone number I have indicated on the patient demographic form. EVI staff will only leave voice messages about your appointment dates and times, balance due on the date of service and/or to request a return call to us. EVI staff will NOT leave messages about your medical condition or any personal medical details. ☐

c) **Payment obligation**:

i. I certify that the demographic information I have given is correct and hereby authorize payment to Espinoza Vein Institute of the beneifts payable to me and to my physician. In applying for payment under Title XVIII of the Social Security Act, I request payment of authorized benefits be made on my behalf to those who accept this assignment. ☐

ii. I agree to pay all co-pay, deductible and co-insurance for each visit at the time of service. ☐

iii. I further understand that I am responsible for any charges not covered or payable by my insurance carrier. ☐

iv. I therefore agree to pay all balances owed to EVI, **within 60 days from the date of the EOB**, for the portion of my bill which my insurance carrier does not cover. ☐

v. Even though Espinoza Vein Institute accepts assignment of insurance company payments, insurance carriers occasionally send payment checks to the patient for services rendered by the physician. I agree to forward any such payments I receive to Espinoza Vein Institute as soon as I receive them. ☐

vi. I understand that, as guided by my insurance carrier, "**Pior Authorization is not a guarantee of payment**" and therefore, in the event of a claim denial, all outstanding fees due to EVI are ultimately my responsibility which I agree to pay to EVI **within 60 days from the date of the EOB.** ☐

d) **Authorization for collection:** Should timely payments not be made on my account, I authorize Espinoza Vein Institute to retain the service of an attorney or collection agency to assist with the collection. Any expenses incurred by Espinoza Vein Institute for such action shall become additional liability for which I assume responsibility. ☐

Patient's Signature: _____ Date: _____/ _____/ _____

Witness: _____ Date: _____/ _____/ _____