CONDITIONS OF SERVICE

Patient Name______________________ D.O.B____/___ /_____

Thank you for choosing Southern Illinois Vein Center for your care. The following are our established conditions of services that will be followed in resolving all issues for services rendered by our staff.

CONSENT TO TREATMENT

The patient consents to the examinations, treatments and procedures while under the care of Dr. Robelen and/or his staff, which may include but are not limited to medical/surgical examinations and treatments, venous ultrasound, sclerotherapy and/or tumescent anesthesia under the general and special instructions of the patient's physician or surgeon.

PRIVATE PAY

For patients having no insurance or choosing not to bill their insurance it is expected that all services will be paid in full at the time of service. For your convenience we will accept cash, check or credit card for payment.

ASSIGNMENT OF INSURANCE

We have made arrangements with a few insurers and health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement. You will be required to pay the deductible and/or co-payment at the time of service.

I, the undersigned, represent that I have insurance coverage with and hereby authorize my insurance company to pay and assign directly to James V. Robelen MD, FACS, dba Southern Illinois Vein Center, all surgical and/or medical benefits, if any, otherwise payable to me for services at a rate not to exceed Southern Illinois Vein Center's regular charges for those services.

If you have insurance coverage with a plan we do not have a prior agreement with, then we will assist you in your claim to your insurance carrier.
You will be responsible, however, for payment in full at the time of service unless other arrangements have been made prior to service.

MEDICARE

Southern Illinois Vein Center does accept Medicare. You will be required to pay the deductible at the time of service unless this is covered by any supplemental insurance you may have.

I, the undersigned, certify that all the information given by me in applying for payment under Title XVlll of the Social Security Act is correct. I authorize release of information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges of the physician charges for his services. I understand I am responsible for any remaining balances.

CONSENT TO PHOTOGRAPH and/or VIDEOTAPING

Southern Illinois Vein Center is permitted to take pictures and/or video of the patient before, during or after treatment in order to document extent of disease, treatment and/or response to treatment involving the patient and to use the same for scientific, educational or research purposes.

PERSONAL VALUABLES

It is understood and agreed that Southern Illinois Vein Center shall not be liable for the loss or damage to any money, jewelry, documents, garments, dentures, eye glasses, hearing aids, prosthetics or other articles of unusual value and small size and shall not be liable for loss or damage to any other personal property.

RELEASE OF INFORMATION

In accordance with HIPAA regulations, Southern Illinois Vein Center will obtain the patient's consent and authorization prior to release of patient's protected health information. Further information will be found in the attached" Notice of Privacy Practices".

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Patient's Signature Date