



Heart Vein & Vascular LLC

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Integrative Cardiovascular Clinic

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HEART
VEIN &
VASCULAR

RELEASE OF INFORMATION AND PAYMENT TO PHYSICIANS

In order to submit a claim for payment for covered services, we must have authorization to release medical information to your insurance carrier.

MEDICARE AND MEDICAID

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 or carriers any Information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

ALL OTHER INSURANCE

I hereby authorize Heart Vein & Vascular LLC, to submit a claim to my insurance carrier or Its intermediaries, for all covered services rendered by the physician(s) and authorize and direct my Insurance carrier or its Intermediaries to Issue payment check(s) directly to the physician(s) rendering the covered services.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

I authorize Heart Vein & Vascular LLC, Babak Alex Vakili MD, to use, disclose and furnish my personal health information, including but not limited to, information about the services rendered to me, as may be requested by my insurance carrier or its Intermediaries, and to those providers of Its treatment, payment, and health care operations and as described more fully In the Heart Vein & Vascular LLC written Notice of Privacy Practices which I have been provided a copy of.

I further agree that I am responsible for paying any balances, which remain after Insurance payments have been made.

Patient Signature _____ Date _____

Spouse Signature _____ Date _____