VEIN & VASCULAR CENTER OF SOUTH FLORIDA

David M. Feldbaum MD FACS   Horacio H. Schlaen MD FACS   Rodrigo B. Fonseca MD

Financial Policy

Thank you for choosing us as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions. They may be reached at 954-964-6684

LIFETIME INSURANCE AUTHORIZATION

Patient's certification authorization to release information and payment request.

I certify that the information given by me in applying for payment is correct. I authorize any medical or other information about me to be released to my insurance company or its intermediary carriers, which includes any information needed for this claim, or any future claim. I also authorize payment of medical benefits to David M. Feldbaum MD PA, or to any of its associates. I understand that I am financially responsible for payment of my medical services to David M. Feldbaum MD PA, regardless of any insurance benefits I may have, and understand that it is my responsibility to collect any reimbursements from my insurance company. I understand that I will be responsible for any fee that might be incurred by David M. Feldbaum and any of its associates, in their efforts to collect fees due to us, including fees from collection agencies, attorney's fees, and court fees.

AUTORIZACION POR SEGURO DE VIDA

Certificacion y autorizacion del paciente para liberar informacion y pedida de pago.

Yo certifico que la informacion dada por mi para pedir pago a mi seguro,es correcta. Yo autorizo cualquier informacion medica que sea necesaria sea notificada a mi seguro o cualquier provehedor intermediario, el cual inluye cualquier informacion necesaria para procesar cualquier reclamo en el futuro. Yo tambien autorizo el pago de beneficios medicos a David M. Feldbaum MD PA o qualquier asociado, Yo entiendo que yo soy responsable financieramente por mis servicos medicos a David M. Feldbaum MD PA o qualquier asociado, a pesar de cualquier beneficios de seguro que pueda tener; tambien entiendo que es mi responsabilidad colectar cualquier reembolso de mi compania de seguro. Yo entiendo que soy responsable de cualquier cargo que pueda ser efectuado por David M. Feldbaum MD PA o qualquier asociado en sus efuerzos de colectar cargos debidos por mi, incluyendo cargos de agencias de recolecta, abogados, o de corte.

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to David M. Feldbaum MD PA and its associates, for services furnished to me by any associate of the office. I authorize any holder of medical information about me to release to ______________________ **(your insurance company)** any information needed to determine these benefits or the benefits payable for related services.

ASIGNSCION DE BENEFICIOS

Yo solicito que el pago de los servicios medicos que han sido autorizados se hagan en mi nombre a David M. Feldbaum MD PA o qualquier asociado de esta oficina. Yo autorizo a cualquier poseedor de informacion medica sobre mi para liberar a ________________________ (su compania de seguros) toda la informacion necesaria para determiner estos beneficios o los beneficios pagaderos para servicios relacionados.

Name (nombre) ______________________ **Patient Signature** (firma)**X** ___________________________________ **Date**(fecha)________