

Patient Waiver/Consent and Agreement to Pay Form

I understand that by signing this agreement, I am authorizing Dr. Mark Zuzga to treat my medical condition. Dr. Mark Zuzga has thoroughly explained the alternative treatments available to treat my medical condition. The known risks have been explained and I am fully aware of the risks involved in the treatment procedure. I am also aware there are risks accompanying any surgical procedure and there is no guarantee on the results of the surgery, as well as, freedom from potential complications.

I acknowledge that every billing effort will be made to my insurer for the reimbursement of the procedure and in the event of insurance denial to pay I agree to be responsible for the full amount of the billed charges or the remaining balance after my insurer has paid.

I give valid consent of the release of all medical record documentation to any insurance company for determination of reimbursement for the treatment procedure. I also authorize all benefit information pertaining to my insurance be released to help in the reimbursement process. My consent is valid for whatever time frame necessary until further notice.

Procedure: _____ Estimated Charges: _____

I have read, understand and have a copy of the Waiver/Consent and Agreement to Pay Form and accept all terms listed above.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____

Witness Signature: _____

Thank you for choosing West Florida Vein Center to provide your surgical care.



Dedicated To Delivering Quality Surgical Care

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