A center exclusively for the treatment of varicose and spider veins

Lori L. Greenwald, MD, FACS
Medical Director

Patient Authorization

Authorization and Release

I hereby authorize payment directly to Lori L. Greenwald, M.D. F.A.C.S. of medical benefits otherwise payable to me. I understand I am financially responsible for any copayments, coinsurance amounts, and deductible that my insurance policy requires. I hereby authorize to release information requested by my insurance company to support payment of my claim.

Name of patient: ____

Signature of patient: ____

Signature of Parent/Guardian of Insured: ______________________________

Date: ______________________

For Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to Lori L. Greenwald, M.D. F.A.C.S. for services provided to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits for services provided to me by that physician for payment of my claim.

Name of patient: ____

Signature of patient: ____

Signature of Parent/Guardian of Insured: ______________________________

Date: ______________________

4.24.08