

Patient's Name: \_\_\_\_\_

Medical Rec #: \_\_\_\_\_

## **Laser Vein Ablation - Acknowledgment of Financial Responsibility**

NOTE: You need to make a choice about receiving this procedure.

We expect that your insurance carrier will not pay for the item(s) or service(s) associated with the laser ablation of the varicose veins in your leg. Insurance does not pay for all of your health care costs, only those items and services which your insurance deems necessary and / or covered under your health insurance policy. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason that your doctor recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. There is no pattern of whether insurance will pay in your case at this time. For example, in some cases, insurance denial for payment may be due to the assumption that this is a procedure that is cosmetic (like facelifts and tummy-tuck types of examinations).

**PLEASE CHOOSE ONE OPTION BELOW. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.**

**Option 1. YES. I want to receive these items or services.**

I understand that my insurance may not pay for this procedure. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, Pueblo Radiology will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, out of my pocket, for these services (not to exceed \$3,500). Appeals to my insurance company will be my responsibility.

**Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I am unwilling to accept the responsibility of paying for these services in the event that my insurance company would not pay Pueblo Radiology for them.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurer.